Health & Families Council

Wednesday, February 22, 2006
9:00 AM – 10:15 AM
212 Knott Building

Meeting Packet

(This is a joint meeting with the Health & Families Council, the Elder & Long-Term Care Committee, the Future of Florida's Families Committee, the Health Care General Committee and the Health Care Regulation Committee)

Allan G. Bense
Speaker

Anna Holliday "Holly" Benson
Chair

Council Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health & Families Council

Start Date and Time:	Wednesday, February 22, 2006 09:00 am
End Date and Time:	Wednesday, February 22, 2006 10:15 am
Location:	212 Knott Building
Duration:	1.25 hrs

The Health & Families Council will meet jointly with the Elder & Long-Term Care Committee, the Future of Florida's Families Committee, the Health Care General Committee, and the Health Care Regulation Committee, for a continuation of the roundtable discussion on trends, opportunities, and challenges in Florida's health care delivery system.

NOTICE FINALIZED on 02/10/2006 10:10 by ISEMINGER.BOBBYE

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Elder & Long-Term Care Committee

Start Date and Time:	Wednesday, February 22, 2006 09:00 am
End Date and Time:	Wednesday, February 22, 2006 10:15 am
Location:	212 Knott Building
Duration:	1.25 hrs

The Elder & Long Term Care Committee will meet jointly with the Health & Families Council, the Future of Florida's Families Committee, the Health Care General Committee, and the Health Care Regulation Committee, for a continuation of the roundtable discussion on trends, opportunities, and challenges in Florida's health care delivery system.

NOTICE FINALIZED on 02/10/2006 13:54 by MANNING.KAREN

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Future of Florida's Families Committee

Start Date and Time:	Wednesday, February 22, 2006 09:00 am
End Date and Time:	Wednesday, February 22, 2006 10:15 am
Location:	212 Knott Building
Duration:	1.25 hrs

The Future of Florida's Families Committee will meet jointly with the Health & Families Council, the Elder & Long-Term Care Committee, the Health Care General Committee, and the Health Care Regulation Committee, for a continuation of the roundtable discussion on trends, opportunities, and challenges in Florida's health care delivery system.

NOTICE FINALIZED on 02/10/2006 14:23 by HINDS.TERRI

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health Care General Committee

Start Date and Time:	Wednesday, February 22, 2006 09:00 am
End Date and Time:	Wednesday, February 22, 2006 10:15 am
Location:	212 Knott Building
Duration:	1.25 hrs

The Health Care General Committee will meet jointly with the Health & Families Council, the Elder & Long-Term Care Committee, the Future of Florida's Families Committee, and the Health Care Regulation Committee, for a continuation of the roundtable discussion on trends, opportunities, and challenges in Florida's health care delivery system.

NOTICE FINALIZED on 02/10/2006 14:08 by RANDOLPH.CHERYL

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health Care Regulation Committee

Start Date and Time:	Wednesday, February 22, 2006 09:00 am
End Date and Time:	Wednesday, February 22, 2006 10:15 am
Location:	212 Knott Building
Duration:	1.25 hrs

The Health Care Regulation Committee will meet jointly with the Health & Families Council, the Elder & Long-Term Care Committee, the Future of Florida's Families Committee, and the Health Care General Committee for a continuation of the roundtable discussion on trends, opportunities, and challenges in the Florida's health care delivery system.

NOTICE FINALIZED on 02/10/2006 14:40 by ALISON.CYNTHIA

The Florida House of Representatives

Health & Families Council

Allan G. Bense
Speaker

Anna Holliday "Holly" Benson
Chair

JOINT MEETING OF THE
HEALTH & FAMILIES COUNCIL
ELDER & LONG-TERM CARE COMMITTEE
FUTURE OF FLORIDA'S FAMILIES COMMITTEE
HEALTH CARE GENERAL COMMITTEE
HEALTH CARE REGULATION COMMITTEE

WEDNESDAY, FEBRUARY 22, 2006
9:00 AM – 10:15 AM
212 KNOTT BUILDING

1. Welcome and Opening Remarks
   Rep. Holly Benson, Chair, Health & Families Council

2. Continuation of the Roundtable Discussion on Trends, Opportunities, and Challenges in Florida's health care delivery system

   Lucy D. Hadi, Secretary - Department of Children & Families
   Carole Green, Secretary – Department of Elder Affairs
   Bonita J. Sorensen, M.D., M.B.A., Deputy State Health Officer – Department of Health
   Alan Levine, Secretary – Agency for Health Care Administration
   Shelly Brantley, M.S.W., L.C.S.W., Executive Director – Agency for Persons with Disabilities

4. Questions & Answers/Discussion – Council and Committee Members

5. Concluding Remarks
   Rep. Holly Benson, Chair, Health & Families Council

200 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 414-5600

Top Ten Trends, Opportunities & Challenges by Department

Department of Children & Families
Department of Elder Affairs
Department of Health
Agency for Health Care Administration
Agency for Persons with Disabilities

Trends, Opportunities and Challenges Relative to DCF Customers and the Florida Health Care System

1. OPPORTUNITY: Explore every possible technology-enabled strategy for public/public and public/private collaboration.

2. CHALLENGE: Facilitate access to Medicaid for eligible low income Floridians through ACCESS FLORIDA. This will include improved customer service and increased efficiency of eligibility processing.

3. OPPORTUNITY: Integrate behavioral health needs of children and adults into Medicaid modernization demonstrations.

4. CHALLENGE: Facilitate access to health insurance for people transitioning from welfare to work including improved coordination of health insurance coverage provided by non-custodial parents.

5. TREND: Implementation of service delivery models—particularly for substance abuse and mental health services—that are driven by consumer direction and informed consumer choice.

6. CHALLENGE: Transform the public-funded substance abuse and mental health by redirecting system resources to recovery-focused treatment.

7. CHALLENGE: Facilitate access to health care for populations with special needs including persons who are homeless or living in homeless shelters, victims of domestic violence and their children, and refugees with cultural and language related barriers to accessing care.

8. CHALLENGE: Improve continuity of health care for children in foster care and children who have been adopted.

9. OPPORTUNITY: Improve access to and quality of publicly-funded substance abuse and mental health services through reforms in contracting that are focused on achieving positive customer outcomes.

10. CHALLENGE: Implement provisions of the Deficit Reduction Act related to nursing home eligibility and restrictions on transfers of assets.

DEPARTMENT OF

ELDER AFFAIRS
STATE OF FLORIDA

JEB BUSH
GOVERNOR

CAROLE GREEN
SECRETARY

Health & Families Council
Roundtable Discussion on Trends, Opportunities and Challenges in Florida's Health Care Delivery System

The following ten issues are critical areas of concern to the Department of Elder Affairs' current focus and future outlook on helping Florida's seniors age in place, age with security, age with dignity, age with purpose, and age in an elder-friendly environment.

Communities for a Lifetime – The department's Communities for a Lifetime program focuses on the challenges that the following issues present for both state and local governments.

1) Transportation Needs.

2) Housing Options.

3) Employment for Elders.

4) Volunteerism & Community-Based Services.

5) Health & Wellness – Preventative Medicine.

6) Intergenerational Connections.

7) Elder Rights & Advocacy.

Delivering Services to the Baby Boomers – The department maintains a key role in dealing with issues created by Florida's increasing senior population, especially when the "Baby Boomer" generation enters the elder service network.

8) Integration & Coordination of Long-Term Care Services.

9) Disaster Preparedness.

10) Alzheimer's Disease & Dementia Research & Services.

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Top Ten Issues from Department of Health Roundtable Discussion

1. EMERGENCY ROOM DIVERSION

- Local community-based primary care programs, such as those administered by federally funded community health centers and county health departments, provide access to health care to persons with low-incomes without health insurance so they have an alternative to going to hospital emergency rooms. Hospital emergency rooms are much more expensive setting, and are not staffed or designed to manage the care of patients over time.

- The Governor's proposed budget for Fiscal Year 2006-2007 recommends the continuation of a $7.3 million local/state/federal partnership that increases funding to federally funded community health centers for primary care. Local dollars are matched with state general revenue, which is in turn matched with federal Medicaid dollars.

2. TOBACCO PREVENTION – DOH PROGRAMS

- Although there have been substantial declines in smoking rates for middle school and high school students over the past 7 years, DOH is concerned that the declines are beginning to level off. Between 1998 and 2005, middle school smoking rates declined by 60.0% and high school rates declined by 42.7%. The Governor's recommended budget for 2006-07 includes an increase of $1.9 million for the Youth Tobacco Intervention Program.

3. FLORIDA'S PRACTITIONER WORKFORCE

PHYSICIAN

- As Florida's health care practitioner workforce strives to meet the growing needs of Florida's population, access to health care is an immediate concern.

- Florida's physician workforce is not growing as fast as its population. Although Florida has the fourth largest population among states, and has the second highest proportion of elderly persons, it is 16th nationally in the number of physicians (246 physicians per 100,000 population). The retirement of physicians, coupled with the advancing age of the "baby boomer" population, is expected to create significant problems in access to care. Unless steps are undertaken to plan and prepare for this eventuality, a situation may occur in which people may have significant difficulties in obtaining physician care.

- Primary care challenges were highlighted in a recent report by the American College of Physicians. The Nation Family Practice Physician Recruitment and Retention Advisory Committee has indicated a concern with a trend

showing a growing shortage of family practice physicians, both Allopathic and Osteopathic.

- The report indicated the following as some of the factors for this decline:
    - falling incomes,
    - difficulties in seeing patients
    - increased costs including malpractice, and
    - policies from insurers that encourage rushed office visits
- It is important to look at policies that could be put into place to address physician shortage problems. It would be important to hear from physician organizations, medical schools, and from the Graduate Medical Education Committee regarding what they believe would be successful approaches.

NURSING

- Nursing shortages exist through the state and high turnover and vacancy rates are affecting access to health care. There are numerous reasons for the shortages including:
    1. Enrollment in schools of nursing is not enough to meet the projected demands.
    2. The shortage of nursing school faculty lead to restrictions in enrollments.
    3. The Average age of the RN is climbing and many are reaching retirement age.
    4. The rate of growth for RNs is the slowest in 20 years.
    5. Many nurses are leaving the profession due to job burnout and dissatisfaction with the job.
- Current nation trends indicate that there are other shortages such as pharmacists, certain medical specialties, allied health care professionals such as medical laboratory personnel, respiratory therapists, and physical therapists. These trends are having a significant effect on health care in Florida.
- The increasing senior population in Florida will require additional health care personnel and services throughout the state.
- These shortages can be addressed through recruitment and retention, streamlining of the licensure processes through technology, process improvement and expansion of medical education facilities.

PUBLIC HEALTH NURSING

- Specific to Public Health, there are many challenges facing our County Health Departments.

    1. The increased number of leadership and public health workforce retiring in the next couple of years makes it imperative that recruitment and retention of public health nurses and public health workforce in general is a top priority.
    2. Even though lack of staff to provide adequate and timely services and lack of time to provide adequate education to patients so that they can understand their illness and comply with treatment faces the CHDs, we must insure client safety.
    3. We must provide education and mentoring of new public health workforce.

- The ongoing education for public health workers related to emergency preparedness and response is critical.

    1. Threats to our health and safety that the nurses and communities face in the form of natural disasters and/or emerging diseases.
    2. Disaster/Emergency Response created a need for resources for Disaster preparation, response and mitigation while maintaining the vital routine of public health initiatives and programs.

- Special Needs Shelters continue to evolve as we address the needs of special needs clients in the state relating to the adequacy of shelters, power supplies, transportation and health care delivery. The Special Needs Shelter Interagency Committee continues to work towards policy changes, operational standards and guidelines for our clients.

4. ACCESS TO HEALTH CARE

- Almost one is five Floridians under the age of 65 (19.2%) lack health insurance.

- Lack of benefits for medical care, either through Medicare, Medicaid, health insurance or other benefit providers is a detriment to regular medical exams, screenings, and other preventative measures that can improve the quality of life for Floridians.

- Some of the challenges being faced by patients include:

    1. Difficulty in coordinating comprehensive services in a decentralized service delivery system.

    2. Health care providers do not always have access to a comprehensive health record.

3. Lack of access to nutrition services for older children and adults which would prevent and/or mitigate the health impacts of the rising incidence of chronic diseases in these populations.

4. Access to health care tends to be available 9-5, Monday-Friday, when the working poor can't take off from work. Encouraging community health care providers to expand hours or establish special alternative times of services, so that community needs are met would help to relieve this problem.

5. CHRONIC DISEASES

- Chronic Diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. These diseases account for 7 of every 10 deaths and affect the quality of life of 90 million Americans. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Adopting healthy behaviors such as eating nutritious foods, being physically active, and avoiding tobacco use, can prevent or control the devastating effects of these diseases.

- In Florida in 2002, chronic diseases accounted for 71% of all deaths. Cardiovascular disease alone accounted for 38% of all deaths. Regular physical activity reduces the risk of dying from cardiovascular disease and developing diabetes or hypertension, and also aids in weight control and maintaining healthy bones, muscles, and joints. In 2002, 27.9% of Florida adults were considered sedentary (participated in no leisure-time physical activities), and only 21.4% participated in regular, vigorous exercise.

- From the CDC publication: The State of Aging and Health in America 2004. "In the United States, 20% of all Americans, or about 70 million people, will have passed their 65th birthday by 2030. The demographic tidal wave is coming. Aging in the 21st century, however, is more than just a matter of numbers. The average 75-year-old has three chronic conditions and uses five prescription drugs."

    - Goals for Improving the Health of Older Americans include:
        - To achieve the national goals for reducing health risk behaviors.
        - To increase opportunities for all older Americans to reap the benefits of regular physical activity.
        - To encourage states and communities to adopt innovative methods to promote healthy aging among the adults they serve.

- To assist in meeting these goals, MIAH, CDC and GSA have included Calls to Action on the following topics related to older adult health:

    1. Monitoring recent physical health.
    2. Addressing frequent mental distress.
    3. Improving oral health.

4. Promoting healthy behaviors.
5. Increasing the use of clinical preventive services.
6. Implementing a national falls prevention plan.
7. Increasing physical activity among older adults.
8. Preparing our health care workforce for an aging society.

6. DENTAL

- Despite the advances and improvements in oral health, dental care remains one of the most prevalent unmet health needs. Disparities in oral health status and access to care affect many persons, but mainly those with low-incomes, members of racial and ethnic minority groups, and the disabled.

- These groups have 2-3 times the dental needs of the average person and have the least access to dental care. Only 11% of low-income persons below 200% of the federal poverty level received at least an annual dental visit through publicly funded and volunteer programs, their main sources of care - 22% for children and 4% for adults. The national average for persons above 200% of the federal poverty level is around 60%.

- Opportunities exist to address these dental care issues. They include:

  1. Continue to expand community and school-based preventive programs (fluoridation and sealants.)
  2. Develop a monitoring system to document oral health status (surveillance.)
  3. Continue to expand community-based and volunteer safety net programs Improve utilization of existing dental workforce for public health facilities Improve the utilization of medical personnel to identify oral diseases, make appropriate referrals and provide primary prevention.
  4. Develop the use of teledentistry to more efficiently utilize the dental workforce.

7. INFANT, MATERNAL, AND REPRODUCTIVE HEALTH

Trends and Challenges

- Transportation to health care services has been identified as a challenge in the MCH five-year needs assessment, Family Planning Program needs assessment, and in the Healthy Start Coalitions' community assessments. Recent increases in gas prices have significantly impacted access to care for both clients accessing services from a health care provider and health care provider that provide home visitation services.

- There is an increase in the number of women of child-bearing age without health care coverage. 28% of Family Health Line pregnant callers stated that

they were not receiving prenatal care due to lack of insurance coverage or financial resources to access care.

- Cervical Cancer screening technology remains an issue. Research studies are not definitive concerning liquid medium pap technology being better than the conventional pap. In the public health setting, not definite if the advanced technology yields sufficient cost savings to replace the conventional technology.

Opportunities:

- Explore the possibility of a multi-agency study with different age groups to identify which Pap technology is best to use for what population of women and how frequent should cervical cancer screening should be provided.

8. ADOLESCENT HEALTH

Trends:

- Obesity - Children who are overweight are at a greater risk for adult onset diabetes, increased severity of asthma, and hypertension.

- Unintentional injuries are the leading cause of death for children and youth, and the fourth leading cause of death for infants less than one year in age.

- Many of the health problems that confront youth today are not typical medical issues. Instead, they are largely behavior and social issues that can result in immediate consequences (death in a car crash), lasting social and economic costs (teen pregnancy) and future chronic health problems (smoking, poor diet and lack of exercise).

Opportunities:

- Youths who are provided support throughout childhood and adolescence are more likely to become healthy, competent, and skilled members of society.

- Promotion of healthy development - Focus on children and young people's assets, promoting healthy development, and adopting non-categorical, ecological strategies that address the multi-level influences on child and adolescent health, such as family, community, schools, society and policy.

- Development and dissemination of report cards on adolescent behaviors related to health.

- Development of a seamless coordination with other agencies serving adolescents or strategies to assure that common issues of risky health behaviors are integrated into other services.

9. SCHOOL HEALTH

- Visits to school health rooms staffed by nurses are more likely to result in students returning to class, reducing the loss of classroom learning time; successfully resolved school health room visits reduce lost work time from parents picking up their children for minor health issues.

- In addition to visits for injuries and acute care, approximately 16% of Florida's kindergarten through 12th grade students have chronic or complex health conditions that need monitoring and services, during the school day. Registered school nurses not only provide health assessment, care planning and services in school, but also refer students for preventive and primary care in their communities. This facilitates access to non-emergency health care services, reduces the patient burden in Florida's emergency rooms and the state's Medicaid expenditures.

10. DISEASE CONTROL

Immunization

- Influenza vaccine: The supply of influenza vaccine has been unstable for the past 4-5 years. Health care providers, both public and private, have had difficulty providing vaccine to their at-risk population and have lost confidence in the influenza vaccine manufacturing and delivery process.

- The Association of State and Territorial Health Officials (ASTHO) made the following two recommendations in January, 2006.

    1. State Health Agencies should be provided with pre-booking, distribution, and shipping data for all flu vaccine within their jurisdiction. Such information should be provided from all manufacturers and distributors, in a secure format, and with provider-level detail.

- During an influenza pandemic, federal, state, and local governments, working collaboratively, must be responsible for determining the allocation and distribution of scarce flu vaccine to ensure that designated high priority populations in all states receive vaccine, as it becomes available, in priority order.

11. BIOMEDICAL RESEARCH

- To compete with other states, and avoid "brain drain", Florida must continue to invest in initiatives to support biomedical and biotechnology research. The Governor's recommended budget for 2006-07 includes an increase from $10 million to $19 million to support research initiatives.

- The Governor's proposed FY 06-07 budget includes funding for Science-based Research Projects, World Class Scholars and Centers of Excellence, and Venture Capital to promote Florida's journey toward being first in biomedical research and cures for disease.

- Compared with other states, Florida universities rank relatively low in NIH funding. In NIH's ranking of the top 500 institutions for 2004, Florida leading research institute is only 58th.

The Agency for Health Care Administration's Top Ten Issues
Health and Families Council, Roundtable Discussion

1. Integrating the Long-Term Care System

- It is estimated that the cost of Medicaid-funded nursing home care will grow from $2.2 billion to $6 billion in ten years. This is a conservative estimate based on an annual growth in caseload of less than 2%.
- Florida has one of the fastest growing elderly populations in the nation. This will be exacerbated by the aging of the Baby Boomer generation. The oldest members of that cohort have just turned 60 years old. In the next 20 years, their needs for both medical and long term care will increase greatly.
- Elders seeking care find a system that is fragmented. Programs have evolved over time and thus do not necessarily coordinate with each other. The programs tend to be designed and governed more by the funding source than for meeting individuals' specific needs.
- Integration of care is critical. Florida is making strides in this area with the proposed Florida Senior Care program. This program will integrate all Medicaid services for Medicaid recipients age 60 or older. One provider will be responsible for ensuring all care needs are met and will have the incentive to provide high quality care and community based services to prevent nursing home placement.

2. Diabetes and Obesity

- "If you go back 20 years, about 2% of all cases of new onset type 2 diabetes were in people between 9 and 19 years old. Now, it's about 30% to 50%," noted Dr. Gerald Bernstein, a past president of the American Diabetes Association (ADA) and an endocrinologist with Beth Israel Medical Center in New York City.
- In the next 25 years, the number of people with diabetes will grow from around 16 million to upwards of 50 million. The cost will be in the hundreds of billions.
- A boy with undiagnosed or untreated type 2 diabetes will have heart, eye, kidney and lower extremity problems by his 30s.
- Disease management provides a strategy for states to improve patient health outcomes and limit health care spending by identifying and monitoring high-risk populations; helping patient and provider populations better adhere to proven interventions; engaging patients in their own care management; and establishing more coordinated care interventions and follow up systems to prevent unnecessary, costly health complications.
- Recognizing the potential benefits of disease management, Florida was one of the first states to invest in disease management to benefit Medicaid beneficiaries.
- Two databases maintained by the Agency's State Center for Health Statistics (Hospital Inpatient and Ambulatory/ED) will continue to provide information on trends in costs and utilization of services for these conditions.
- The data can reveal geographic or subgroup "hot spots" where inappropriate utilization may be occurring, highlight trends in utilization and costs over time, and show the effects of health programs that target these conditions among specified patient groups or areas of the state.

3. Nurse and Allied Health Staffing

- Ten years ago, the average age of a nurse was someone in their 30s. Presently, the average age is someone in their mid-40s. The average age of a nurse in Florida is 47.3 years old compared to 43.3 nationally.
- As nurses retire, the pool of qualified staff to replace them is dwindling.
- Nurse education programs continue to report turning away thousands of qualified applicants because of shortages of faculty, classroom space, and clinical sites for students. In Florida the average age of nursing faculty is 56.2.
- The number of nurses is expected to grow by 6% by 2020, while demand for nursing care is expected to grow by 40 percent.
- The Bureau of National Statistics (BLS) reported the 2003 national mean annual wage of an RN was $51, 230; and for an LPN $33,210.
- In Florida, according to FAWI statistics the mean annual wage of an RN was $47,549, for an LPN $22,880.

4. Alzheimer's

- Alzheimer's Disease is estimated to contribute 25-30% to the cost of long-term care. In Florida it is estimated that 396,000 individuals are afflicted with the disease and it is estimated that this will increase to over 700,000 in the next 20 years.
- Florida will continue to be disproportionately affected, since it has one of the fastest growing elderly populations in the nation. It is estimated that after age 60 one in ten individuals has the disease; after age 85 fifty percent of individuals have the disease.
- In terms of health care expenses and lost wages of both patients and their caregivers, the cost of Alzheimer's disease nationwide is a staggering $80 to $100 billion per year. The yearly cost of caring for one Alzheimer's patient is $18,400 for mild symptoms, $30,100 for moderate symptoms, and $36,132 for advanced symptoms. The average direct cost of caring for an Alzheimer's patient from diagnosis to death is $174,000. The average annual cost for nursing home care in the U.S. is approximately $52,200.
- The Alzheimer's Association reports that American businesses spends $61 billion a year on Alzheimer's disease, a twofold increase from the amount calculated just four years ago and a dollar amount equivalent to the net profits of the top 10 Fortune 500 companies.
- Florida is piloting a Medicaid home and community based program targeted at individuals with Alzheimer's Disease who can still live at home and who have a caregiver. The goal is to determine whether a more targeted approach leads to better outcomes than treating these individuals in a more general program for people with disabilities. One improved outcome would be that the program's services allow an individual to stay in their home longer, rather than having to move to an assisted living facility or nursing facility.
- Although improved services for individual's with Alzheimer's Disease may help reduce the cost of caring for this population and reduce the burden on families, it will not ultimately solve the problem. It is critical that we find ways to prevent, control, and ultimately eradicate the disease. Support for clinical research into the disease and treatments is critical.

5. Racial and Ethnic Disparities

- In 1980, there were 9.7 million people in Florida, and 85% of our population was white. Today, we are more than 16 million people and we are 82% white. In 2020, we will be 23 million people with 79.5% white. Florida's population is becoming more diverse and therefore the issue of disparities becomes even more urgent.
- 15% of the state's population is African American, but they make up more than 50% of our HIV/AIDS cases. Diabetes occurs more often among racial and ethnic minorities than among non-minorities, with a larger proportion of African Americans and Hispanics carrying the burden of the disease.
- Minorities in America face severe economic, cultural, linguistic and physical barriers for treatment of mental illness, difficulties that prevent thousands from being properly treated.
- 1/3 of Hispanics are uninsured. 23% of African Americans are uninsured.
- The Agency recognizes the disparity of health care in racial, ethnic, and rural populations and is working to level the playing field by increasing access to care for these populations.
- Under Medicaid Reform, recipients will be provided information and education aimed at reducing health disparities and increasing health literacy when they receive choice counseling. Florida is the first state in the nation that will include health disparities and health literacy as components of choice counseling.
- Medicaid Reform provides incentives for early detection of chronic diseases. 50% of the state's Medicaid population is African American and Hispanic, making these populations prime beneficiaries of early detection of chronic diseases.

6. Health Information Technology

- Healthcare data is usually stored on "islands" of information, and whether those islands are bits and bytes or paper, the island's data is only available to its inhabitants.
- The health care system has grown too complex to manage by paper alone.
- The change to health information systems will not just happen – it needs concerted action, requires leadership and public-private partnerships.
- The Governor's Health Information Infrastructure Advisory Board (GHIIAB) has recommended and the Agency has made available grants of $1.5 million to nine projects involved in planning, training and implementation of health information exchange. The Florida Health Information Network (FHIN) grants program has created great interest in the health care community and has induced a great deal of creative activity in developing health information networks.
- In the Governor's Recommended Budget for FY 2006-07, he has requested $5 million for the FHIN grants program.
- Electronic Health Records (EHRs) can help avoid the costs of preventable medical errors.
- Dr. David Brailer, National Health Information Technology Coordinator, estimates that simply by using electronic records, we could save between 7.5 and 30% of our nation's $1.6 trillion of expenditures in health care.
- Research argues that with the introduction of EHRs, physician decision-making will transform from decisions based on training to decisions that are evidence-based. Medical decision-making will also become more patient-centered, more responsive to patient needs and values.

- Ability to make the system more transparent. Patients will control access to records. Patients will have electronic access to their medical records using personal health records unique identifiers.

7. Bioterrorism Readiness

- Current limited health care facility capacity, should the need for massive numbers of hospital beds occur.
- Impact on health care staffing.
- Ongoing education of health care staff.
- Increase efforts to ensure Florida residents and their families are prepared.
- There is no government bureaucracy that can take the place of people simply being prepared.
- Apply the systems methods developed from the state's hurricanes, as they are also applicable to terrorist events.

8. Transparency of the System

- The state's first step was www.FloridaCompareCare.gov, which is the only one of its kind in the nation.
- FloridaCompareCare allows a consumer to select between inpatient care in hospitals and outpatient care in ambulatory surgery centers or in hospitals, based on health care conditions or on the geographic location of the facility. Consumers can generate comparative reports on hospitals for the patient safety indicators and for medical conditions or charges for procedures. Reports on ambulatory surgery facilities provide the number of visits and charges for procedures.
- Transparency is key to measuring outcomes. These measures will become the benchmark for hospital and institutional improvement. Now we must refine the data, and continue identifying meaningful measures.
- Medical errors are likely to be reduced by making health care data transparent.

9. Access to Care in Rural Communities

- Concern for the safety net. While rural hospitals are smaller in size and scope than hospitals in or near larger cities, they often anchor the health care safety net for large rural regions with few health care providers. Rural hospitals are particularly important for uninsured or underinsured people with limited transportation options in emergency situations.
- Over 24 of Florida's counties are rural.
- Ability to attract physicians and capital investments
- Lack of health care professionals that are willing to relocate and work in rural communities.

10. The Uninsured – Financing

- According to the Florida Health Insurance Study, between 1999 and 2004, the statewide percentage of Floridians under age 65 who are uninsured increased from 16.8% to 19.2%.
- Among adults, the largest increase was among young people age 19—24 years old, with over a third (35.1%) uninsured in 2004 compared to 27.1% in 1999.

- Employment status is also a critical factor related to health insurance coverage. According to the 2005 Florida Health Insurance Study, almost half (48.1%) of those who are unemployed lack coverage, and almost a third (32.0%) of the self-employed are uninsured.
- The uninsured currently receive many services from emergency admissions to hospitals, county public health clinics, rural health clinics, and federally qualified health centers. Some counties also target local funds towards coverage initiatives that pay for bundled services of limited benefits, such as certain primary care services, hospitalization, and limited pharmaceuticals.
- Hospital finances are supported by both the Medicaid Disproportionate Share Program (DSH) and the Medicaid Inpatient Upper Payment Limit Program (UPL), which provide resources to the hospitals as they provide care to both Medicaid and the uninsured. State general revenue and local tax funds support the clinic services, as well as limited grants from the federal government.
- Next year, the state could spend as much as $1 billion on the UPL program, $300 million for DSH payments to hospitals, $300 million for rebasing of hospitals, plus millions more on cost-based reimbursement of health departments, federally qualified health centers and rural health clinics. These dollars are spent in a fragmented manner for the purpose of creating access for the uninsured or compensating providers who care for the uninsured. Additionally, hospitals lose billions of dollars on charity and other uncompensated care for which they receive no funding.
- The state is spending an enormous amount of resources already, but in a fragmented way. The natural question, then, is whether or not there is a more thoughtful and systemic approach to funding coverage for the uninsured, many of whom are hard working Floridians one paycheck away from disaster if they encounter a sudden medical catastrophe.
- Each day that goes by, we move closer to a government funded system as our medicaid and SCHIP roles grow and as the pressure increases to fund other programs to provide access to the uninsured. Each of these programs becomes incremental rather than systemic, and is an inefficient use of these dollars.

11. Medicaid Transformation

- The total Medicaid budget for SFY 2006-07 is projected to increase 5% in total expenditures. However, with a Medicaid budget of almost $16 billion, annual growth at this moderate percentage is approaching $1 billion of growth per year.
- This issue is further complicated by how Medicaid is funded, and the 5% growth masks the 12% growth of General Revenue need. The state cannot continue to do business as usual, but must go forward with reform to learn how to create a controllable system.
- Medicaid Reform presents the opportunities to learn and expand our knowledge of a different delivery system, one that integrates services and focuses on the monitoring and evaluation of that system to meet the needs of our recipients.

12. Integration of Developmentally Disabled and Mentally Ill into the Community

- The past 30 years have shown great progress in moving people with developmental disabilities and mental illness out of institutions to live in community settings. The next step is to change the systems of care to allow them to more fully integrate into

their communities so that they can live full lives, working towards the same goals that people without disability have—meaningful work, independence, and self-determination.

- In the mental health system, this system transformation is towards recovery based services. This recognizes that people with severe and persistent mental illness may never be "cured," but that with the appropriate supports they can live meaningful lives.
- For people with developmental disabilities, self-direction has been the key, allowing publicly funded supports to be more flexible by allowing individuals with disabilities and their families to make decisions about who will be caregivers and allowing them to use the budget for care in the way that best suits the individual. There are still many barriers to this kind of flexibility, and more work is needed to find the right balance between flexibility and accountability for public funds.
- Advances in medical care have lead to individuals with developmental disabilities living longer than before. This is leading to a growing challenge of individuals with disabilities outliving their caregivers. It is imperative that services be designed to teach the individual independence and self-reliance, to the maximum extent possible, rather than fostering dependence and limiting individuals' potential.
- Increase service providers that are trained in and dedicated to the philosophy of care to foster independence, so that lack of appropriate providers does not deter moves towards more independence for people with disabilities

13. Agility of Regulatory Process to Accommodate for Technology and Ability to Measure Outcomes.

- Focus less on process and more on outcomes. This is the natural byproduct of transparency.
- Moving Open Heart from CON to outcomes based licensure is one good example.
- Savings in both money and lives will accrue to the transparent regulatory system that rewards acceptable outcomes and ignores the more time-consuming reviews of the processes that created them—and reviews processes only for unacceptable outcomes.

14. Centers of Excellence

- Florida has many fine hospitals which provide high quality of care and which offer excellent specialized services:
- At Jackson Memorial, Dr. Tzakis, is a world renowned transplant surgeon, specializing in multiple organ transplants. Shands Gainesville has many research programs and specializes in the neurosciences. Florida also has the H. Lee Moffit Cancer Center and Research Hospital, specializing in cancer treatment. However we have no nationally recognized Centers of Excellence
- Florida needs to work on promoting existing facilities and their programs, as well as promoting new programs and new entrants. When Mayo Clinic purchased St. Luke's Hospital and eventually established their liver and lung transplantation programs, rather than diminish the volume of transplantations performed by other programs...all program volumes increased and the level of organ donations increased.
- Centers of Excellence bring in researchers, grants and innovation; they help forward the quality of services provided.

Agency for Persons with Disabilities
Top Ten Medical Priorities for 2006

- **D**evelopment of available capacity of health care professionals (physicians, dentists, clinical psychologists and allied health care) who have appropriate training and experience in treating children, adolescents and adults, including those from socio-economically and linguistically diverse communities

- **A**ccess Psychiatric/Psychological/Mental Health services for individuals with developmental disabilities who, like the general population, have service needs but require customized delivery methods

- **D**ecrease the statewide nursing shortage, which greatly affects the ability to serve individuals with developmental disabilities who have complex or ongoing medical needs in community settings

- **D**evelop specialized programming and treatment options for aging persons with developmental disabilities and their caregivers.

- **E**nsure access to preventative medicine for those individuals with developmental disabilities

- **R**esearch, evaluate and fill medical insurance coverage gaps experienced by individuals with developmental disabilities

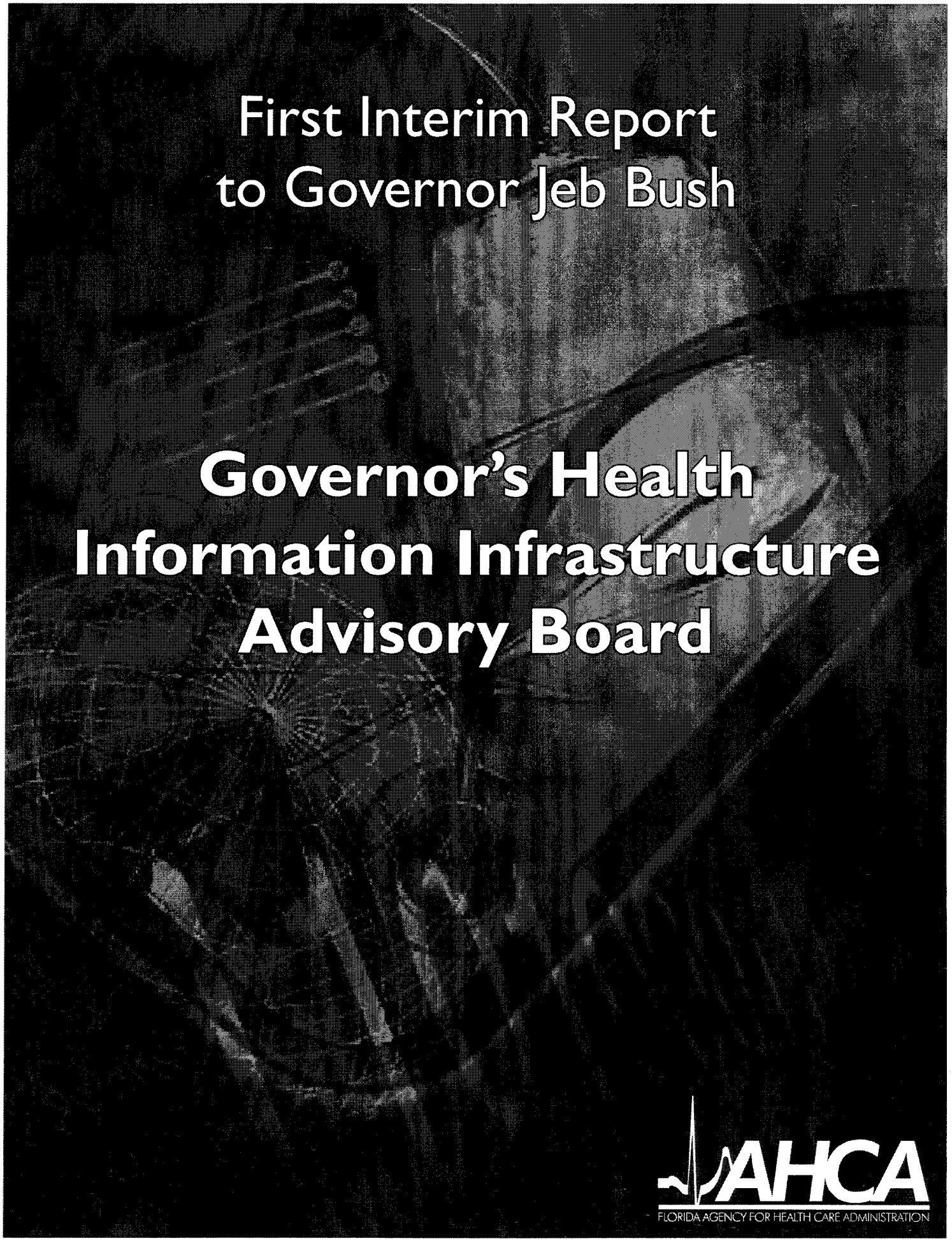
- **S**upport continued and expanded efforts in the areas of infant screening and genetics research and service provision

- **P**rovide and support consistent behavioral health services to persons with developmental disabilities across all home, education and employment systems

- **D**evelop adequate and accurate medical history and data for the healthy existence of all Floridians with developmental disabilities

- **C**ontinue to provide education and awareness and training to clients, families and staff concerning the Zero Tolerance Against Sexual Violence

Health Information Technology



First Interim Report
to Governor Jeb Bush

Governor's Health Information Infrastructure Advisory Board

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Table of Contents

Executive Summary

Introduction.

There is a growing appreciation in America of the gap between the current state of healthcare delivery, and what would be possible with the effective use of information technology. Recognition of that gap is giving rise to a consensus among providers, consumers, and other stakeholders that information technology can improve healthcare at least as much as it has improved the financial services, transportation, manufacturing and retailing sectors. This unique consensus affords the State of Florida and the nation a significant opportunity for collaboration among all healthcare stakeholders to develop an effective health information system.

Vision.

The Florida Health Information Network (FHIN) will connect the state's healthcare stakeholders through an integrated information system. It will be a secure network that will make available to authorized parties the medical information they need to make sound decisions about healthcare, regardless of where that information is stored, and where or when it is needed. Computerized "decision support" programs will automatically analyze all available health information and complement the data available through FHIN with clinical logic and practice guidelines. Decision support will assist both consumers and providers in making personal and clinical decisions based on sound medical science.

Providers will be liberated from a practice model based on their capacity to memorize a multitude of potentially relevant facts and recall them all during the encounter; rather, they will focus more on the patient and the science and art of healing. The healthcare system supported by FHIN will be centered on the consumer, empowering the public to direct their healthcare using readily available comprehensive information about their health, and transparent information about the advisability of competing healthcare choices that they face.

Public health officials will be empowered to detect, monitor and deal with emerging health threats more efficiently. The time it takes to bring medical discoveries from the laboratory bench to the hospital bedside will be slashed.

Strengths, Weaknesses, Opportunities and Threats.

The state starts down the path toward implementing FHIN with certain strengths, including executive and legislative support for the undertaking, general support among some physician groups, and a culture of innovation in state healthcare programs. There are weaknesses as well in the current state environment, including the low usage of

electronic health record systems by Florida providers, and the absence of a proven business model for the operation of FHIN.

To be successful, the state must capitalize on the opportunities which are present, such as the strong national momentum for electronic health information systems, and growing provider interest in such systems and recognition of the inevitability of EHR's in the future of medicine. Similarly, certain threats must be eliminated or minimized, including the perception among certain stakeholders that the privacy laws forbid or severely restrict the sharing of health information, and concerns among some providers of an increased risk of medical malpractice liability that might result from the sharing of information from third-party electronic sources.

Obstacles.

There are two large, but surmountable, obstacles to fully implementing FHIN – the low number of healthcare providers who have adopted electronic health record systems, and the lack of an infrastructure to share health information effectively. The challenge will be to develop a compelling mix of incentives to motivate providers, payors, consumers and other stakeholders to participate in the migration to a model of healthcare based on an effective, integrated information system.

Strategic Framework.

Those two over-arching obstacles suggest a two-pronged strategic framework for making FHIN a reality. First, promote adoption of effective electronic health record systems among Florida providers. There will be a number of possible initiatives to promote adoption of EHR's. Second, develop the FHIN infrastructure. The infrastructure needed for FHIN includes technical elements such as transmission facilities and data standards. Good progress is being made on those technical elements. Other, non-technical considerations will also be needed for FHIN's success operation. Those include the network's business model, legal form, participation agreements and governance structure. Those elements are not yet developed, and may pose a greater challenge than the technical elements.

There are few operating health information networks that can provide a successful model for a sustainable network in Florida. It would be advisable for the state to develop FHIN by launching pilot projects and refining the model through experience with the operation of the network. Successful pilots could be expanded and merged, thereby developing FHIN incrementally through accretion.

Recommended Actions.

To execute under the strategic framework, the Board recommends a number of actions, including the following:

1. Partner with stakeholder groups in programs to promote adoption of EHR's by the state's healthcare providers.

2. Start immediately to develop FHIN through incremental steps.

3. Coordinate all health information initiatives and programs of the State of Florida to provide impetus for FHIN.

4. Develop a public information plan to educate and inform the stakeholder groups in a coordinated manner about the FHIN initiative and its benefits for the state healthcare system.

5. Organize periodic meetings with the counterpart HII boards of other states to exchange knowledge and collaborate where that would be productive.

6. Promote Florida representation on national health information boards.

Conclusion.

The structure of the healthcare system in America is unique among the country's business sectors. In the past, there have been rational reasons for healthcare's reluctance to adopt information technology solutions. It is now time for the healthcare system to take full advantage of the power of information technology to reduce medical errors and to raise the bar on the quality and efficiency of care delivered in our country.

The gathering momentum for change is one of FHIN's resources that must be carefully used and not squandered. The FHIN initiative must demonstrate steady progress according to a realistic plan. It is also critical that status reports and major accomplishments be communicated effectively to stakeholders. Success will breed success in this initiative.

The main challenges we will face are not likely to be technological. Rather, the "human" issues will predominate. Cooperation among competitors, trust among parties who have historically faced off antagonistically, and willingness to consider changing established habits to serve this higher purpose will be critical success factors. State leadership in these areas may make the difference between success and failure.

Foreword.

There is a growing appreciation in America of the gap between the current state of healthcare delivery, and what would be possible with the effective use of information technology. Recognition of that gap is giving rise to a consensus among providers, consumers, and other stakeholders that information technology can improve healthcare at least as much as it has improved the financial services, transportation, manufacturing and retailing sectors. In fact, dramatic improvements in healthcare delivery are already occurring in other parts of the country with the adoption and effective use of integrated health information networks.

This unique consensus affords the State of Florida and the nation a significant opportunity for collaboration among all healthcare stakeholders to develop an effective health information system. In Florida, there have been a number of calls among political leaders and policymakers for action in developing such a system.[1]

The Governor's Task Force on Access to Affordable Health Insurance called for the utilization of electronic health information and encouraged the development of electronic medical records (EMR's) by providing financial incentives and promoting the use of digital technology and information systems.[2] In addition, the Select Committee on Affordable Health Care for Floridians, in its final recommendations to the Speaker of the House, recommended the adoption and use of technology supporting a single medical record.[3] Both recommendations gave rise to the passage of House Bill 1629 in May 2004, which requires the Agency for Health Care Administration (AHCA) to develop and implement a strategy to adopt and use electronic health records (EHR's).[4]

Background of the Governor's Health Information Initiative.

On May 4, 2004, by Executive Order No. 04-93, Governor Jeb Bush created the Governor's Health Information Infrastructure Advisory Board. The Board's mission expressed in the Executive Order is to i) advise and support AHCA as it develops a strategy for adoption and use of EHR's and creates a plan to promote the development

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1. *See, e.g.,* Governor Jeb Bush and Lieutenant Governor Toni Jennings, *Promoting Access to Affordable, Quality Health Care*, January 27, 2004, http://www.fdhc.state.fl.us/affordable_health_insurance/020204_meeting/health_care_white_paper_012704.pdf.

2. On August 25, 2003, Governor Jeb Bush issued Executive Order No. 03-160, creating the Governor's Task Force on Access to Affordable Health Insurance chaired by Lt. Governor Toni Jennings and Chief Financial Officer Tom Gallagher. The 17-member task force consisted of business leaders, health policy experts, healthcare providers and consumers.

3. August 14, 2003, Speaker Johnnie Byrd created the Select Committee on Affordable Health Care for Floridians. Representative Frank Farkas, D.C, chaired this 15-member House Committee.

4. *See,* sec. 408.062, Florida Statutes (2004).

and implementation of a Florida health information infrastructure (HII), including measures to promote greater adoption of EHR information systems among the state's healthcare providers; ii) identify obstacles to the implementation of an effective HII in the state and provide AHCA policy recommendations to remove or minimize those obstacles; iii) advise the Executive and Legislative branches on issues related to the development and implementation of the Florida HII; and iv) assist AHCA in ensuring that the strategy and plan preserve the privacy and security of health information as required by law.

The members of the Board include:

- **Carmen Aceves-Blumenthal**, Pharmacist, McKesson Medication Management
- **Robert G. Brooks, MD**, Former Secretary, Florida Department of Health, former state legislator, Associate Dean for Health Affairs, Florida State University College of Medicine
- **Ronald R. Burns, DO**, Private Family Practice, Winter Park, and President, Florida Osteopathic Medical Association
- **Raymond F. Caron, MD, JD**, Private Pediatric Practice, Orlando
- **Brian O. Coleman, DMD**, Omega Dental Group, Winter Park
- **Jeannette W. Ekh**, Group Vice President and Chief Information Officer, Blue Cross Blue Shield of Florida
- **Michael Heekin**, Chair, Governor's Health Information Infrastructure Advisory Board
- **Kevin S. Kearns**, Chief Financial Officer and Chief Information Officer, Health Choice Network
- **Rhonda M. Medows, MD**, Former Secretary, Agency for Health Care Administration, Physician, Jacksonville
- **Linda E. Moody, PhD**, Professor, University of South Florida College of Nursing
- **James S. "Sandy" Phillips,** Chief Information Officer, Jackson Health System, and
- **Robert G. Reese**, Chief Information Officer, Memorial Healthcare System.

The Board held several organizational telephone conferences during the summer months of 2004, and the first of four workshop meetings in October 2004. It has actively sought the advice of national experts on electronic health information systems and a number of Florida stakeholders, including providers, consumers, payors and purchasers, on possible approaches to planning, implementing and operating an effective and secure health information infrastructure in Florida.[5] Board members have also reviewed much of the abundant, high quality academic, industry and policy literature that is being published on integrated health information networks and related topics.

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5. At its first workshop, the Board also received testimony on the lessons learned from last season's four hurricane strikes regarding the design of an electronic health information system to facilitate disaster response. A summary of that testimony is attached as Exhibit 1.

As a result of its fact-finding work, the Board has developed a preliminary outline of some of the strengths, weaknesses, opportunities and threats the state and its healthcare stakeholders can expect to encounter as they work to implement a statewide health information network. Such a "SWOT" analysis is a common part of the strategic planning process. The Board will continue the SWOT exercise as it performs its work, and will incorporate the results into its final recommendations. A summary of the preliminary SWOT analysis is attached as Exhibit 1.

Using the Board's findings and conclusions to date as the foundation, this report describes a preliminary strategic framework and recommends key actions for the advancement of the state health information network. Although the Board has been actively pursuing Governor Bush's charge articulated in the Executive Order, much remains to be done to reach the ultimate goals. The Board will continue its work, and anticipates developing a more comprehensive strategic plan for the state during this calendar year.

The Board welcomes comments, questions and advice on the matters raised in this report, and the direction to be taken as it continues its work.

An Overview of American Health Information Systems.

Health information is generally stored on "islands" of information at the facilities of the healthcare providers who generate the information. Even if a healthcare provider is among the minority that has an electronic health record system (EHR) [6], until that system is connected to the EHR systems of other providers in the region, there is no effective and timely means to share the health information. Rather, it remains "trapped on the island," generally unable to have an impact on the subject's healthcare delivered anywhere beyond the shores of that island, or even beyond the part of the island on which the information resides.

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6. An electronic health record system, also known as an electronic medical record or a computer-based patient record, is an information system which houses a health record. It is designed to provide users with access to complete and accurate clinical data, practitioner alerts and reminders, clinical decision support systems, and links to medical knowledge resources. *Health Information Management: Concepts, Principles, and Practice.* LaTour, K.M. and Eichenwald, S., 2002. Chicago: American Health Information Management Association.

In a letter report to the U.S. Agency for Healthcare Research and Quality, the Institute of Medicine states that an EHR system includes (1) longitudinal collection of electronic health information (i.e., collected and maintained over a considerable period of time, ideally, from birth to death) for and about persons, where health information is defined as information pertaining to the health of an individual or healthcare provided to an individual; (2) immediate electronic access to person- and population-level information by authorized, and only authorized, users; (3) provision of knowledge and decision-support that enhance the quality, safety, and efficiency of patient care; and (4) support of efficient processes for healthcare delivery. Critical building blocks of an EHR system are the electronic health records (EHR) maintained by providers (e.g., hospitals, nursing homes, ambulatory settings) and by individuals (also called personal health records). Institute of Medicine, "Key Capabilities of an Electronic Health Record System," July 31, 2003, http://books.nap.edu/html/ehr/NI000427.pdf.

The lack of effective access to clinical health information at the point of critical decision-making means that:

- Providers often must make significant decisions without the benefit of many critical facts and access to the latest relevant scientific findings;
- Quality and safety of the healthcare delivered without complete information are not as good as they could be in an information-rich healthcare system;
- Money is spent unnecessarily on duplicative tests and procedures;
- Opportunities exist for public health officials to improve timely access to information needed for public health activities such as disease surveillance, outbreak detection and emergency response; and
- Consumers are not able to participate meaningfully in the critical decisions regarding their health or the health of family members under their care.

Vision.

In contrast with these challenges is the vision of a Florida Health Information Network (FHIN) in which the state's healthcare stakeholders are connected through an integrated information system. FHIN would be a secure network that could make available to authorized parties the medical information they need to make sound decisions about healthcare, regardless of where that information is stored, and where or when it is needed. Access to scientific research would be streamlined. Computerized "decision support" programs could automatically analyze all available health information and complement the data available through FHIN with clinical logic and practice guidelines. Decision support will assist consumers and providers in making personal and clinical decisions based on sound medical science.

Providers could be liberated from a practice model based on their capacity to memorize a multitude of potentially relevant facts and recall them all during the encounter; rather, they could focus more on the patient and the science and art of healing. The healthcare system supported by FHIN would be centered on the consumer, empowering the public to direct their healthcare using readily available comprehensive information about their health, and transparent information about the advisability of competing healthcare choices that they face.

Public health officials would be empowered to detect, monitor and deal with emerging health threats more efficiently. The time it takes to bring medical discoveries from the laboratory bench to the hospital bedside would be slashed.

Florida's Opportunity.

There is a gathering consensus among Florida's healthcare stakeholders that it is time to move forward in developing a trusted health information network such as the one described above. Unlike the conditions that have prevailed in previous attempts to implement such networks, the technology now exists to create an effective health information exchange. There are good arguments that over time, such a system will pay for itself[7] and spawn a new age of healthcare innovation and discovery.

The challenge is to develop a compelling mix of incentives to motivate providers, payors, consumers and other stakeholders to participate in the migration to a model of healthcare based on an effective, integrated information system.

Obstacles.

There are two large, but surmountable, obstacles to fully implementing FHIN – the low number of healthcare providers who have adopted electronic health record systems, and the lack of an infrastructure to share health information effectively.

Low Adoption Rate of Electronic Health Record Systems.

In order to have an effective information system, health information must be:

- electronically captured at the point of care,
- electronically stored in a secure fashion, and
- electronically retrievable by authorized parties wherever they or the data may be located.

From a purely technological standpoint, it is possible today to store electronic health information in an interoperable system (i.e., one that is connected to permit two-way flow of data) and to retrieve that data from any place that has Internet service. However, the healthcare system is not generally capturing data electronically at the point of care.

Nationally, studies indicate that fewer than 10% of physician offices rely primarily on electronic health record systems in their practice to record and manage clinical health information. With respect to hospitals, recent data from Florida suggests that only 40% of acute care facilities use electronic health records in at least one area of their

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7. *See, e.g.*, J. Walker, E. Pan, D. Johnston, J. Adler-Milstein, D.W. Bates, B. Middleton, "The Value of Health Care Information Exchange and Interoperability," *Health Affairs*, 19 January 2005, http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1?eaf

organization. Most departments in hospitals and almost all physicians still do not use this technology.[8]

Lack of Infrastructure to Exchange Health Information.

Fortunately, because of the development of the Internet, there is not generally a need to build a new physical network to connect providers and other FHIN participants in Florida. There are a few exceptions to this – the possible need for better high-volume Internet access in some rural areas and the advisability of overbuilding a layer of redundant infrastructure in some existing coverage areas. In addition, there are other infrastructure "building blocks" which will be needed to operate FHIN.

First, there are technical elements such as data standards, common medical terminology and reporting formats, and privacy and data security methods. Good progress is being made on those fronts at the national level, and it is anticipated that those technical elements will be available when and to the extent they are needed for deployment in FHIN.

Second, there are a number of non-technical infrastructure elements that are still far from being ready for deployment in the state's health information network. Those elements include:

- Legal matters such as the form of entity which could operate FHIN most effectively, the terms of the participation agreements with providers in the network to define the legal rights and responsibilities of each, and the state and federal laws and regulations necessary to operate the network effectively;

- FHIN's business model, which includes how the development and operation of the network will be financed, how the network will actually operate on a day-to-day basis to protect the privacy of consumers and the security of their data and to fulfill the network's mission, and how the network will be marketed to providers, consumers, payors and other stakeholders to promote participation and maximize use of the network; and

- Governance arrangements such as how the network will be operated, how the governing board will be chosen and how policy decisions will be made.

Development of those non-technical elements will likely prove more challenging than the technical elements identified above.

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8. Menachemi, Burke, Brooks, (2004) Adoption Factors Associated with Patient Safety Related Information Technology *Journal of Healthcare Quality* 26(6), 39-44.

Strategic Framework.

Those two over-arching obstacles suggest a two-pronged strategic framework for making FHIN a reality:

1. Promote adoption of effective electronic health record systems among Florida providers. The plan to accomplish this is likely to include many initiatives, such as:

- Reducing providers' financial and business risk of purchasing an EHR system through programs that test and certify EHR products as meeting certain recommended standards, and through consumer ratings of competing systems conducted by providers themselves, negotiating price concessions on EHR systems through group purchasing arrangements, and promoting the availability of competent technical support at a fair price;

- Promoting continuing medical (and professional) education in subjects that familiarize providers with EHR's and their use in a healthcare practice;

- Training providers on the use of electronic health information systems beginning in medical and nursing schools and internship and residency programs;

- Encouraging EHR adoption through workshops sponsored by professional societies (the Florida Academy of Family Physicians is exemplary in this effort – it sponsored a successful EHR adoption workshop in May 2004, and is planning another one in April 2005 in conjunction with other physician specialty associations);

- Structuring financial incentives for EHR adoption through methods such as increased reimbursement to providers if they employ EHR systems in their practice; and

- Establishing the use of an EHR system as a billable procedure, just as the use of an MRI or X-ray is billable.

As part of its mission articulated in the Executive Order, the Board will continue work in this area and submit recommended specific strategies to promote greater adoption of EHR's among Florida's providers.

2. Develop the FHIN infrastructure. Florida must begin developing the network's infrastructure, especially the non-technical elements discussed above, even as we work to promote the adoption of EHR's. Having infrastructure in place, in itself, will encourage adoption of EHR's by providers. The more authorized parties that share health information on the network, the more useful the network will be to all of them. That increasing usefulness will attract further network participants, which will start the cycle all over again.[9]

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9. That cycle of increasing utilization is known as the "network effect." The first articulation of the principle is attributed to Bob Metcalfe, co-inventor of the Ethernet networking protocol and co-founder of 3Com.

In order for that process to work, however, the network must create trust and prove itself useful to the participants. Features such as online coordination of care among a patient's providers, clinical messaging (to permit the convenient transmission of health information between providers) and benchmarking (to inform providers of their performance in patient outcomes compared with their peers) are among the uses that might promote utilization of the network.

Because of the currently low rate of EHR usage, the body of clinical data available to be shared over FHIN will be limited when it is first launched. However, there are valuable collections of health information that are already available in electronic form from at least three sources:

- **Claims forms filed by providers with payors:** Most Florida providers now submit medical claims in an electronic format. Those claim forms include data on the patient such as name, demographic information, treating and referring physician, dates of service, diagnoses, and treatment procedures performed in the encounter. Florida Medicaid currently uses electronic claims submissions to capture much of that information.

- **Medication prescriptions stored by the pharmacy benefit managers:** Prescription data is generally already stored in standardized electronic format. Information about what drugs a patient is currently taking could provide valuable information about the patient's health status.

- **Test results maintained by laboratories:** Lab test results may prove to be the hardest of these three data types to incorporate into FHIN. Lab work in America is performed by a fragmented collection of laboratories in hospitals, independent facilities and clinics. FHIN will be required to negotiate with a number of businesses who may store their test results data according to any of several different data standards, and who may not be motivated to cooperate in developing the interface for FHIN to access their data. However, the reward for accomplishing this will be great. Lab results are a powerful source of data on a patient's health status, even more so when several lab values taken over time are compared with one another to check for trends in the patient's readings.

Integrating these three data sources into one report in a standardized, easily readable format will give authorized providers ready access to information on a patient's prior or current medical conditions and treatment. That report available at the point of care will be a valuable tool to coordinate care with the treatment a patient is receiving from other providers, even providers in the same healthcare institution. Such data could also form the foundation for decision support tools to assist providers in delivering quality, safe care based on sound, current medical science and would empower public health officials in performing their duties such as outbreak monitoring.

Other HII organizing groups around the country are already using those data sources in pilot projects to build their infrastructure. Of course, as an increasing number of

providers implement EHR systems and make their electronic health information accessible through FHIN, the network's data set will become more complete, making reference to the health information on FHIN ever more integral to the delivery of care.

Recommended Actions.

To execute under the strategic framework outlined above, the Board recommends that AHCA consider the following initiatives as part of the plan to promote the development of FHIN:

1. **Partner with provider associations and other stakeholder groups in programs to promote adoption of EHR's by the state's healthcare providers.** There is momentum building among Florida providers to adopt EHR systems in their practice. Organizations such as the Florida Academy of Family Physicians are affirmatively working to encourage EHR adoption among their members and to make the transition to electronic health as smooth as possible. The state can partner creatively with such groups to add greater momentum. An appropriate starting point could be a program with incentives to physicians to implement and use EHR's as part of an initiative to improve adherence to recommended preventive and chronic disease services.

2. **Start immediately to develop FHIN through incremental steps.** Florida starts on the path to electronic health with an abundance of good advice that has not been extensively tested in the field, and with few successful operating models to emulate. Academic, industry and public policy reference sources are rich in studies on all facets of developing, implementing and operating a health information network. Nevertheless, there are only a small number of actual operating networks, and few of those have developed sustainable, replicable business models. More abstract study of the issue would not result in any significant benefit to the FHIN initiative, and strictly adhering to the preliminary experience of other networks is not feasible.

   The state should pursue a "launch and learn" approach. However, launching a statewide comprehensive health information network in one massive rollout would not be advisable – in the absence of a proven business model, the risk of failure would be unacceptably high. Rather, the Board recommends that the state employ a controlled launch and learn approach – by encouraging qualified sponsoring groups to plan, launch and operate a limited number of carefully chosen and designed pilot projects of manageable size and scope with AHCA's oversight and support. Those pilot projects can provide FHIN the "real world" opportunity to develop the infrastructure in a controlled manner.

For this approach to succeed, proper selection of the pilots will be critical. The Board has developed a set of criteria by which proposed pilot projects can be evaluated for support by AHCA.[10] Those criteria include whether the pilot:

- Provides for privacy and security of health information, and permits the consumer to grant or withhold access to his/her health information;
- Enhances opportunities for consumer input on treatment options and includes a consumer access component such as a personal health record that provides the consumer with the information to act proactively in managing his/her health;
- Gives providers the ability to examine the aggregate outcomes of care and benchmark their performance;
- Makes effective use of medical evidence in clinical decision making to reduce practice variations that are not based on patient preference or clinical severity;
- Operates according to a feasible implementation plan that focuses first on "low-hanging fruit";
- Employs a sound evaluation methodology with well-defined financial and quality of care metrics to demonstrate improved patient outcomes and operational efficiencies with quantifiable data;
- Enhances coordination of care by giving the healthcare provider access to records of healthcare the patient is receiving concurrently by other providers;
- Is scalable (i.e., able to be expanded to larger areas and patient populations) and replicable (i.e., the pilot model can be reproduced in other parts of state);
- Is led by a strong organizing group with project champion(s) from the relevant healthcare communities (physicians, hospitals, etc.), and representatives of important stakeholder groups; and
- Leverages existing infrastructure and utilizes established national standards.

The Medicaid Gold Standard system is perhaps the most compelling example of existing Florida health information infrastructure on which pilot projects might build. Under that electronic prescribing system, Florida Medicaid is deploying interactive handheld computers to 3,000 of Medicaid's highest prescribing volume physicians throughout Florida. Medicaid recently launched a web based

10. A complete statement of the pilot evaluation and selection criteria recommended by the Board are attached in Exhibit 2.

version of the program that is available to every Medicaid physician in the state (15,000 total providers). This number represents 30% of the physicians in Florida who can now exchange information electronically on their Medicaid patients' medications to prevent adverse drug interactions, over-prescribing of the same or similar drug by different physicians, or the improper use of narcotics.

The Gold Standard system provides state-of-the-art electronic prescribing services as part of the medical care provided to over 1.5 million Floridians enrolled in the commercial Medicaid program or certain of the state's largest Medicaid HMO's. The program has consistently reported high return on investment to the state, demonstrating that the implementation of successful health information technology infrastructure can save lives and save money. It would be highly advisable for one or more pilot projects to build on that considerable footprint, expanding the program to include other patient populations and/or other types of health information (e.g., lab values, encounter data, etc.).

Another example of existing infrastructure on which pilot projects might build is the Florida State Health Online Tracking System (SHOTS). That system is a statewide computerized pediatric immunization information registry. The Department of Health recently announced that use of the SHOTS system is now available to Florida's private healthcare providers. A pilot project that based on the possible expansion of that database to make more health information available to pediatricians and other authorized users in the care of Florida's children is worthy of early attention.

As the models of the pilot projects are refined and proven through operating experience, the project can be expanded to larger areas and/or patient populations. It can also be replicated elsewhere in the state. In that way, FHIN can be built incrementally through the accretion of pilot projects and their offspring with manageable risk, cost and disruption to the state's healthcare delivery system.

3. **Organize meetings with the counterpart HII boards of other states to exchange knowledge and collaborate where that would be productive.** This will permit FHIN and its counterparts in other states to reach consensus at the state level as to what can best be handled locally, and what the states should properly commit to the Office of the National Coordinator for Health Information Technology for federal action. For example, technical standards are clearly a matter for national action to ensure that all participating states' networks can connect effectively to one another and the national network. Similarly, the state HII groups can collectively identify those issues that should properly be reserved to the states for action. The meetings will allow state groups to share knowledge systematically on lessons learned, comparing notes on successful approaches to developing and implementing state health information networks.[11]

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11. In addition to state health information exchange projects, there are other groups whose experiences in this area deserve close study. The U.S. Department of Veterans Affairs operates a network known as the

4. **Coordinate all health information initiatives and programs of the State of Florida to provide impetus for FHIN where appropriate.** The state is one of the largest providers and payors of healthcare services in Florida. The state government should use its status to provide leadership in the efforts to establish FHIN just as the federal government has through its Consolidated Health Informatics Initiative. For example, the market presence of the Division of State Group Insurance should be coordinated where appropriate with that of Florida Medicaid and other state programs to ensure that they are focused on the same goal of an integrated, secure Florida health information network. Similarly, the health information infrastructure initiatives of all state health activities, from Children's Medical Services to county health department clinics to Healthy Kids to the Department of Corrections should be coordinated with the FHIN initiative to contribute to the critical mass that will be needed for FHIN to succeed.

5. **Pursue a diversity of funding sources for FHIN.** Last year, the U.S. Agency for Healthcare Research and Quality awarded $139 million in contracts and grants to promote the use of health information technology through the development of networks for sharing clinical information. Only two Florida groups were among the successful applicants, receiving a total of $349,069. [12] There were grants awarded by philanthropies and other non-federal sources as well, and certain parties in the vendor and payor communities have committed resources to health information initiatives in other states. The state should encourage and support a diversity of funding sources for FHIN's development.

6. **Propose and support legislation to accommodate the operation of FHIN.** There are a few legislative proposals that AHCA should consider supporting in the 2005 Legislative Session to promote the establishment of FHIN. Those proposals might include:

    a. Continuing medical education courses in electronic health information topics as described above;

    b. Permissive increased reimbursement of providers by payors depending upon the use of EHR's in the practice;

Veterans Health Information Systems and Technology Architecture (VistA). The VA's system is recognized as one of the best integrated health information models in the world.

12. On a positive note regarding federal funding, in September 2003, the U.S. Health Resources and Services Administration (HRSA) awarded Florida-based Health Choice Network a grant totaling $3.3 million over three years. At the same time, HRSA awarded a grant of $467,000 to Collier Health Services, in cooperation with the Community Health Center Alliance. Those grants were both intended to assist community health center groups to improve their clinical information systems.

c. Statutory authority for a state coordinated health initiatives program; and

d. Rationalization of Florida Statutes with HIPAA in the area of electronic health information.

In addition, the launch of pilot projects over the next year is likely to show the need for further legislation to facilitate FHIN's successful, safe and secure operation. Areas for legislative attention in the future may include creating safe harbors for practitioners utilizing FHIN, and updating statutory provisions on medical records issues, including establishing legal definitions for recently developed health informatics methods and concepts.

As part of the process of coordination with counterpart groups from other states, the Board recommends that AHCA encourage a joint effort among the states to develop model health information infrastructure laws. Uniform state laws dealing with health information issues will greatly assist the effort to implement a national infrastructure. The Board recommends that AHCA consider pursuing federal sponsorship of that model legislation project.

7. **Develop a public information plan to educate and inform the stakeholder groups in a coordinated manner about the FHIN initiative and its benefits for the state healthcare system.** There is momentum building around the consensus to change the status quo. However, to maintain that momentum, it will be important to educate Florida's health stakeholders about FHIN and the effect it will have on them and the state's healthcare system, and to keep them informed from time to time about the progress of the FHIN initiative. The issue is complicated, and must be introduced to stakeholders in phases over time. That requires a coordinated plan.[13]

8. **Form strategic partnerships with key parties in the healthcare community.** There are a number of parties – state and federal governmental entities, professional associations, businesses and individuals – whom AHCA needs as partners in strategy to make FHIN a successful reality. Those parties need to be true partners – with shared vision, shared risk and shared reward. Examples of potentially important strategic partners in the public sector are Florida Medicaid, the Florida Department of Health and the Florida Division of State Group Insurance.

13. In particular, there is a need across stakeholder groups for education about the effect of HIPAA and related laws on the ability to share health information among healthcare stakeholders. There is a wide disparity of understanding about what is legally permitted. To promote the development of FHIN and give consumers the protections to which they are legally entitled, the Board recommends early attention to programs to educate stakeholders on the proper interpretation of the privacy laws.

9. **Promote Florida representation on national health information boards.** The effort to establish FHIN will be a long and complicated process, requiring effective coordination with federal and national policy-making, regulatory and standards-setting groups. Florida representation on national forums throughout the life of this initiative can help shape the national agenda and promote Florida's "agility" in response to national developments.

Conclusion.

The structure of the healthcare system in America is unique among the country's business sectors. In the past, there have been rational reasons for healthcare's reluctance to adopt information technology solutions. Those reasons are rooted largely in the way in which the financial aspects of the healthcare system developed in America. That time has passed. It is now time for the healthcare system to take full advantage of the power of information technology to reduce medical errors and to raise the bar on the quality and efficiency of care delivered in our country.

The gathering momentum is one of FHIN's resources that must be carefully used and not squandered. The idea of a comprehensive integrated health information network has been tried several times before and has failed. Some providers can be expected to approach this initiative with skepticism that has to be overcome with some early wins. The FHIN initiative must demonstrate steady progress according to a realistic plan in order to prove that this time is different. It is also critical that status reports and major accomplishments be communicated effectively to stakeholders. Success will breed success in this initiative.

The professional associations who are taking the lead on this important undertaking are to be commended and encouraged to continue their good work. The state's political leaders are also to be commended for their vision in supporting the development and implementation of an effective health information network for the state to promote the delivery of 21st Century quality healthcare to all Floridians.

On the path ahead, the main challenges we will face are not likely to be technological. Rather, the "human" issues will predominate. Cooperation among competitors, trust among parties who have historically faced off antagonistically, and willingness to consider changing established habits to serve this higher purpose will be critical success factors. Perseverance will prove that the goal is achievable – an integrated health information system that can make available to authorized parties the medical information they need to make sound decisions about healthcare, regardless of where that information is stored, and where or when it is needed.

Exhibit 1
Analysis of Strengths, Weaknesses, Opportunities and Threats
Regarding Initiative to Establish the
Florida Health Information Network (FHIN)

Strengths[14]	Weaknesses[15]	Opportunities[16]	Threats[17]
• Florida's executive leadership is driving the vision of a Florida Health Information Network, and is strongly and publicly committed to its realization. • Strong support among legislative leadership. • Strong support for EHR's among some physician groups (e.g., Florida Academy of Family Physicians EHR workshops and other programs).	• Currently low usage of EHR's by providers, especially physicians. • Lack of proven business model for the operation of FHIN. • Perceived lack of incentives for EHR adoption in physician practices, especially among small and/or rural providers. • Sizable financial investment to adopt and EHR's,	• National momentum and bi-partisan support for electronic health information systems. • Growing provider interest in electronic health information systems and recognition of inevitability of EHR's in medicine of the future. • Increasing public policy measures promoting electronic health, e.g., Medicare Modernization Act requirement of e-prescribing.	• Perception among some Florida healthcare stakeholders that privacy laws found in HIPAA and elsewhere forbid or disfavor sharing health information among authorized parties could impede development of FHIN. • Concerns over privacy and data security may impede development of FHIN or curtail some features that would otherwise prove helpful.

14. **STRENGTHS:** Capabilities and resources in Florida on which the initiative can capitalize as a basis for developing FHIN.

15. **WEAKNESSES:** Areas in current capabilities and resources that might prevent Florida from developing FHIN.

16. **OPPORTUNITIES:** Positive trends, events, and ideas in the current state and national environment that can be harnessed to increase prospects for success of FHIN. Opportunities may include favorable attitudes among stakeholders, emerging technologies, etc.

17. **THREATS:** Negative trends, events, and ideas in the current environment that must be managed or mitigated to prevent their decreasing the prospects for success of FHIN.

• Culture of innovation in state healthcare programs, e.g., Medicaid Gold Standard program. • Payor market share leaders have tradition of innovation and forward thinking initiatives. • Healthcare information highways are operational in Florida – substantial interoperability already established for sharing healthcare administrative information among providers, payors and other stakeholders. • Standards adoption rate is high and accelerating; progress has been made by the federal Consolidated Health Informatics initiative in adopting 20 clinical and messaging standards to be used by federal agencies. • Much of technology and physical infrastructure needed for FHIN exists today. • Progress made to date among providers and	considerable risk of failed EHR implementation in present environment. • Current lack of alignment between the stakeholders who stand to benefit most from migration to electronic health information environment, and those who are expected to pay for that transition. • Currently no common vision among stakeholders of FHIN and the strategy for its development. • Relatively small consumer involvement to date in promoting development of FHIN. • Understanding of/support for FHIN varies across government officials (legislators, regulators, key staff). • Large number of seasonal residents and tourists make maintaining complete electronic health record more challenging. • Lack of consensus on methodology or	• Building consensus among employers and payors that electronic health is one important element of quality and cost containment initiatives. • Accelerated growth in consumer-directed health plans and expanded Internet use for medical information has increased consumer involvement in healthcare decisions. • EHR product certifications and consumer ratings of competing products have leveled playing field, reducing risk of EHR adoption by provider. • Florida is significant market participant in national healthcare market; under proper circumstances, can exert coordinated influence over progress of steps toward electronic health environment. • Open standards, architecture and source code should help unlock islands of electronic information currently stored under proprietary standards. • Increased provider	• Perception among providers that there is an increased risk of medical malpractice liability with EHR's is likely to slow adoption. Two specific areas of concern are that reliance on incorrect information found on health information network could cause adverse medical event and that easier access by plaintiffs to medical information through EHR's could increase legal exposure. • Florida's physicians are operating primarily in small practices, not large group practices in which technology adoption is more likely. • The value proposition for each of the constituents (e.g., patients, purchasers, payers and providers) is not well understood, possibly stalling efforts to move rapidly. • Lack of federal government adoption of Internet usage, e.g., CMS transactions cannot be conducted over

payors in compliance with HIPAA standards shows moderate readiness to adopt new technology under proper circumstances. • Large population of elders population can sharpen focus on critical end-of-life issues. • Increasing number of Florida providers making the transition to paperless EHR systems could permit a more complete set of electronic health information in FHIN and could build momentum for adoption of EHR's. In the latest example of this trend, Baptist Medical Center South in Jacksonville is scheduled to open in February 2005 as a paperless facility. *See, e.g.,* M.C. Moewe, "Baptist South to go 'Paperless,'" *Jacksonville Business Journal*, January 21, 2005. • Pharmacy industry currently sharing medication information among providers, pharmacies, payors and pharmacy benefit managers;	infrastructure to uniquely identify patient (e.g. master patient index). • Disparate payor/ provider/vendor systems with limited capability of interoperability. • Complex standards adoption process. • Current lack of alignment between state and federal laws. • Laws and regulations that were written prior to emergence of modern health information technology may be too restrictive for successful development and operation of FHIN. • Stark, antikickback and antitrust laws may impede ability of providers to take many economically rational actions that would otherwise promote adoption of EHR's. • Substantial disparity in motivation, technological sophistication and resources across physician offices,	involvement in developing standards, such as the continuity of care record format, may lead to greater acceptance. • Federal involvement (CMS directives) will drive adoption of electronic health. • Fairly concentrated payor community in Florida enables focused efforts with fewer players. • Small, but growing number of operational regional and state health information networks affords opportunity to learn from experience of others. • Possibility of coalition among state HIT efforts across nation, permitting systematic transfer of knowledge, insights and lessons learned to accelerate state efforts in Florida and elsewhere; preliminary federal interest in promoting and supporting that coalition. • Florida representation on national forums can influence national agenda and ensure Florida's "agility" in response to national developments.	the Internet. • Vendors and other stakeholders may resist adoption of interoperability standards; may develop proprietary/private networks or lobby for proprietary standards to their advantage. • Florida's highly privatized hospital system may not lend itself to sharing of resources among communities or within some highly competitive local environments. • Balancing policy needs may create disagreement among stakeholders about priority of FHIN – possible criticism that funds to be spent on developing FHIN ought to be spent on other priorities. • Conversion to electronic information system will require maintenance of parallel paper- and electronic systems during transition period. • "Tower of Babel" will result if pilot projects fail to

could use that existing infrastructure for expanded purposes.	hospitals, labs, and other providers. • Diversity of Florida marketplace may present both cultural and language challenges for access and adoption. • Wide diversity in healthcare delivery systems in Florida (e.g., rural areas that don't have or are slow to adopt technical capabilities).	• Federal government appears likely to continue its existing program of awarding contracts and grants for health information demonstration projects to qualified groups, providing a possible source of funding for Florida pilot projects.	comply with established standards and are unable to communicate with other systems. *See, Book of Genesis, 11:1-9.* • "We've always done it this way": transition to electronic health practice model will require changing the mindset of generations of healthcare providers.

Exhibit 2
Health Information System
Lessons Learned from 2004
Hurricane Strikes

The hurricanes visited upon the people of Florida human tragedies and property damage of incredible scale. As tragic as they were, these storms gave Florida's healthcare stakeholders the opportunity to learn lessons regarding the design, implementation and operation of health information systems to deal with the challenges to public and personal health and minimize the adverse impact of widespread disasters.

At its workshop on October 7 and 8, 2004, the Governor's Health Information Infrastructure Advisory Board received testimony on the lessons learned from last season's four hurricane strikes from healthcare professionals who participated in the emergency response. The panelists included:

- Dr. Karen A. Chapman, Okaloosa County Health Department Director;
- Mr. Mike Hill, Administrator/Health Officer, Okeechobee County Health Department;
- Mr. Mike Smith, Chief Information Officer, Lee Memorial Health System; and
- Dr. Bonita J. Sorensen, Deputy State Health Officer, Florida Department of Health.

Lessons Learned:

1. The first area of concern was understandably the basic infrastructure – anything "with wires," whether power or telecommunications, was problematic in the initial aftermath.
    a. Redundancy of communications methods proved critical – mobile telephones, radio, Blackberry's, etc.
    b. Basic power and communications infrastructure needs to be more robust to support information networks and other systems dependent on infrastructure.
    c. Multiple back-ups are necessary because systems will fail.
2. An online, real-time assessment of the readiness posture and available capacities of the state's health facilities – hospitals, nursing homes, labs, pharmacies, etc. – would be helpful.

a. Such an inventory should include information on bed capacity, generator ability, availability of vaccines, oxygen, medications and other vital supplies, etc.

b. During an emergency, a status assessment of these assets could begin to establish the current state of the health facilities in the affected region. That information would be used to help the Florida Department of Health and Department of Emergency Management Services move resources to where they are needed. Or, conversely, patients could be moved to areas that have the resources they need.

c. Such an online single point of access would address several challenges that manifested themselves in the 2004 storms:

    i. In performing their oversight and care coordination duties, various state and federal agencies require repeated updates on the same readiness and utilization information. Those inquiries could have been handled more efficiently and with less disruption of the ongoing emergency operations at the healthcare facilities through the system described above.

    ii. Not only were "direct-hit" facilities impacted by the storms and stretched to their limits, but so too were facilities within the unaffected surrounding regions. These surrounding facilities felt the impact of patient transfers, emergency room visit diversion and overall increased utilization. The system would permit better load balancing among all health facilities.

    iii. Although hospitals and nursing homes were generally prepared to deal with the emergencies, other minor, but critical, businesses in the healthcare delivery system were sometimes shut down before, during and well after the storm, and therefore unavailable to contribute to the disaster response. An example is some durable medical equipment suppliers. Online access to a real-time assessment of their status would be helpful.

    iv. Most emergency plans covered the immediate time frame of the emergency. Once the "all clear" was sounded, emergency teams stepped down. That proved to be the case for the regional facilities, which then found themselves back in emergency situations due to patient diversion from the direct hit areas.

3. Access to patients' health records would have helped significantly. Health records that patients carried with them proved very useful – access to information as simple as a one-page summary of health status such as a hospital discharge summary or patient face sheet made a big difference. Helpful basic information

includes current diagnoses, medications, immunizations, plan of care, identification of providers and their emergency contact information. Immunization records for adults would have been helpful; e.g., did someone cut up in the storm need a tetanus shot?

4. For special needs patients, acute medical needs are likely to emerge during and in the immediate aftermath of a disaster. Access to the health records of allied health professionals such as nursing homes and home health providers would be helpful.

Exhibit 3
Recommended Criteria for Selection and Evaluation of Health Information Exchange Pilot Projects

I. The pilot project must:

1. Address important problems/underserved populations in initial phase, focusing on one or more chronic populations

2. Leverage existing infrastructure, utilize existing national standards and provide for the privacy and data security of participants

3. Provide for privacy and security of health information, and permit the consumer to grant or withhold access to his/her health information

4. Have visible sources of funding for development costs through in-kind contributions, philanthropy, state and federal grants and contracts, etc.

5. Execute against a feasible implementation plan that focuses first on "low-hanging fruit" and expands incrementally from the starting point

6. Operate under a sound legal, financial and governance structure and evaluation methodology with well-defined financial and quality of care metrics demonstrating improved patient outcomes with quantifiable data

7. Enhance coordination of care by giving the healthcare provider access to records of healthcare the patient is receiving concurrently by other providers

II. In an early phase, but not necessarily at "go-live," the pilot must:

1. Include public health functionality (e.g., Florida SHOTS, Healthy Start, etc.)

2. Make effective use of medical evidence in clinical decision making to reduce practice variations that are not based on patient preference or clinical severity

3. Give providers the ability to examine the aggregate outcomes of care and benchmark their performance

4. Enhance opportunities for consumer input on treatment options and include a consumer access component such as a personal health record that provides the consumer with the information to act proactively in managing his/her health

III. The pilot ought to:

1. Be implemented within 180 days

2. Be scalable (i.e., able to be expanded to larger geography and patient populations) and replicable (i.e., the pilot model can be reproduced in pilots in other parts of state and other patient populations)

3. Include a public information plan to promote stakeholders' understanding of critical issues such as privacy and information security

4. Be able to demonstrate an existing IT infrastructure capable of accommodating the pilot project

5. Be housed by a 'neutral' party, not an individual healthcare stakeholder

6. Initially focus on improvements in chronic disease management with measurable improvements in patient compliance and outcomes, such outcomes measurements on his/her/its patients made available to participating healthcare providers

7. Improve decision-making at the pharmacy by giving the pharmacist access to a complete ethical and OTC drug record

8. Be "provider-friendly" – e.g., compatible with current healthcare provider workflow, provide realistic incentives for stakeholders to participate in pilot project and promote adoption of EHR's

9. Include a physician portal with functionality that assists the physician in personalizing the delivery of healthcare

10. Be led by a strong organizing group with project champion(s) from the healthcare communities (physicians, hospitals, etc.), and representatives of important stakeholder groups

IV. The pilot preferably should:

1. Have a financial plan feasibly showing the potential for financial sustainability and expansion of the system after the initial pilot phase

2. Include a feasible technical paradigm that is consistent with the goals of scalability and replicability, and addresses issues such as:

    a. EDI with pharmacies
    b. Normalization of data received (i.e. lab value ranges) from different sources (QC component)

c. Interchange of XML data (both HL7 and non-HL7) - web based repository
d. Integration of Provider based EHR systems

3. Demonstrate the ability to interface with the Medicaid Gold Standard project to allow sharing of key Medicaid clinical information

Exhibit 4

Glossary of Acronyms Used in Interim Report

EHR – Electronic Health Record

EMR – Electronic Medical Records

FHIN – Florida Health Information Network

HII – Health Information Infrastructure

HIPAA – Health Insurance Portability and Accountability Act

HIT – Health information technology

IT – Information technology

Just Read, Florida!

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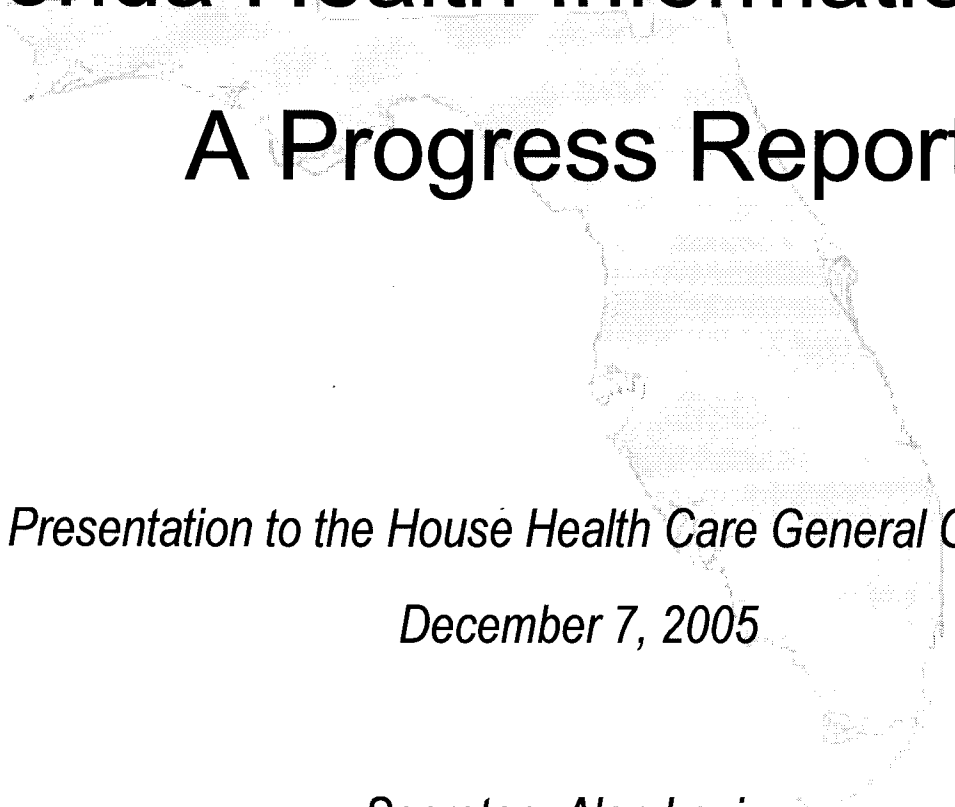
Florida's Health Information Infrastructure

The Florida Health Information Network: A Progress Report



Presentation to the House Health Care General Committee

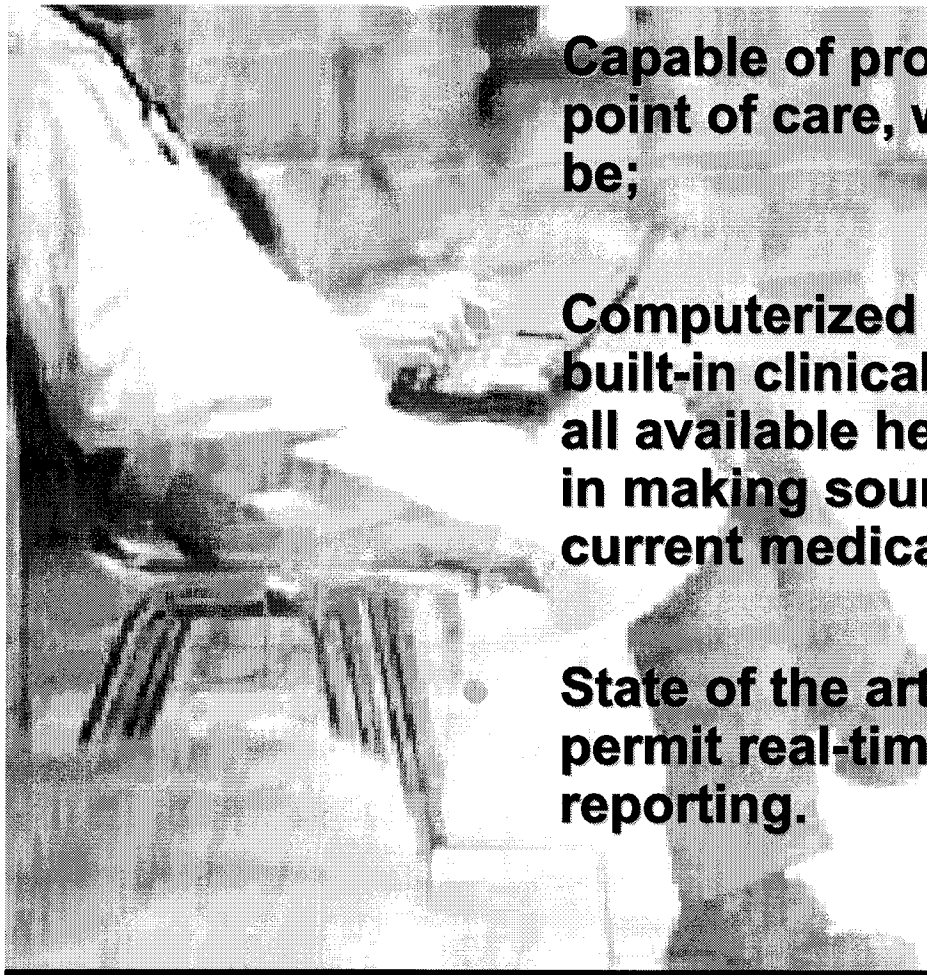
December 7, 2005

Secretary Alan Levine

Agency for Health Care Administration

The Vision:

A comprehensive integrated network of health privacy-protected record systems among the state's health care stakeholders.



Capable of providing medical information at the point of care, whenever and wherever that may be;

Computerized "decision support" programs – built-in clinical logic that automatically analyzes all available health information to assist providers in making sound clinical decisions based on current medical science;

State of the art public health functionality to permit real-time outbreak monitoring and disease reporting.

The Governor's Health Information Infrastructure Advisory Board

- **Appointed by Governor Jeb Bush in June 2004**
- **Mission:**
  - Advise Governor and Agency for Healthcare Administration on the development of the Florida Health Information Network – "FHIN"
  - Identify obstacles to the implementation of FHIN and provide policy recommendations to remove or minimize those obstacles
  - Assist in ensuring the privacy and security of personal health information on the network

Conclusions of GHIIAB after one year on the job . . . .

1. The goals of the GHIIAB and the Florida Health information Network will not be accomplished without strategic partners. Stakeholders in the state are generally supportive of the FHIN, but more providers need to come to the table to learn and communicate.

2. Launch and learn.

3. We should foster pilot projects which are modest in scope and scale to progress deliberately.

    - Start modestly, refine model, scale up and out, and develop FHIN cumulatively.

    - Be a good steward of invested funds ~ prove concepts on modest scale before seeking substantial commitment of resources.

More conclusions . . .

4. Implementation of FHIN can be accelerated by sharing resources and lessons learned among states – don't reinvent the wheel (same thing within the state).

5. We need effective stakeholder information and education efforts to "pull" FHIN through the challenges that it will face; FHIN must be marketed like any other product or new idea.

6. Educating stakeholders on HIPAA and other privacy laws as they relate to operation of a health information network is a must.

7. **State medical records laws across the nation need to be updated and harmonized with each other. Areas where some states laws differ include**

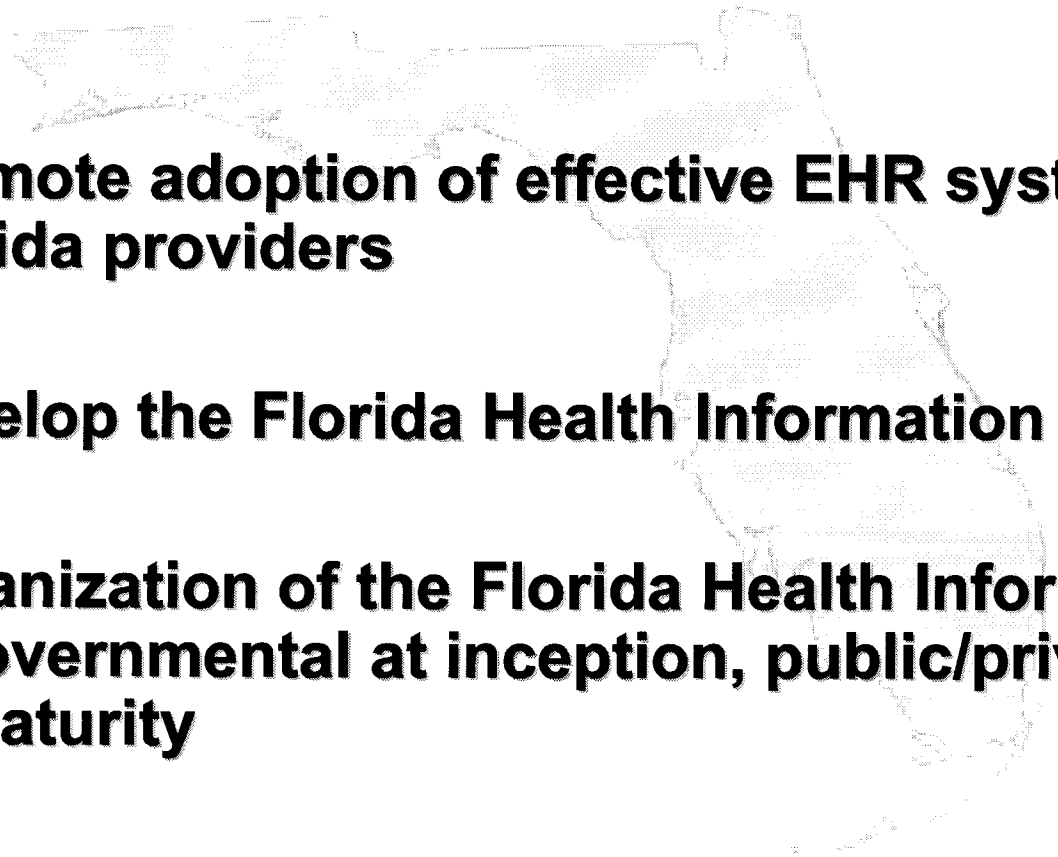
- **Mental Health**
- **HIV/AIDS**
- **Patient consent requirements**
- **Medicaid State Plan Administration**
- **Special program restrictions**
- **Physician self-referral laws/regulations**

. . . and more . . .

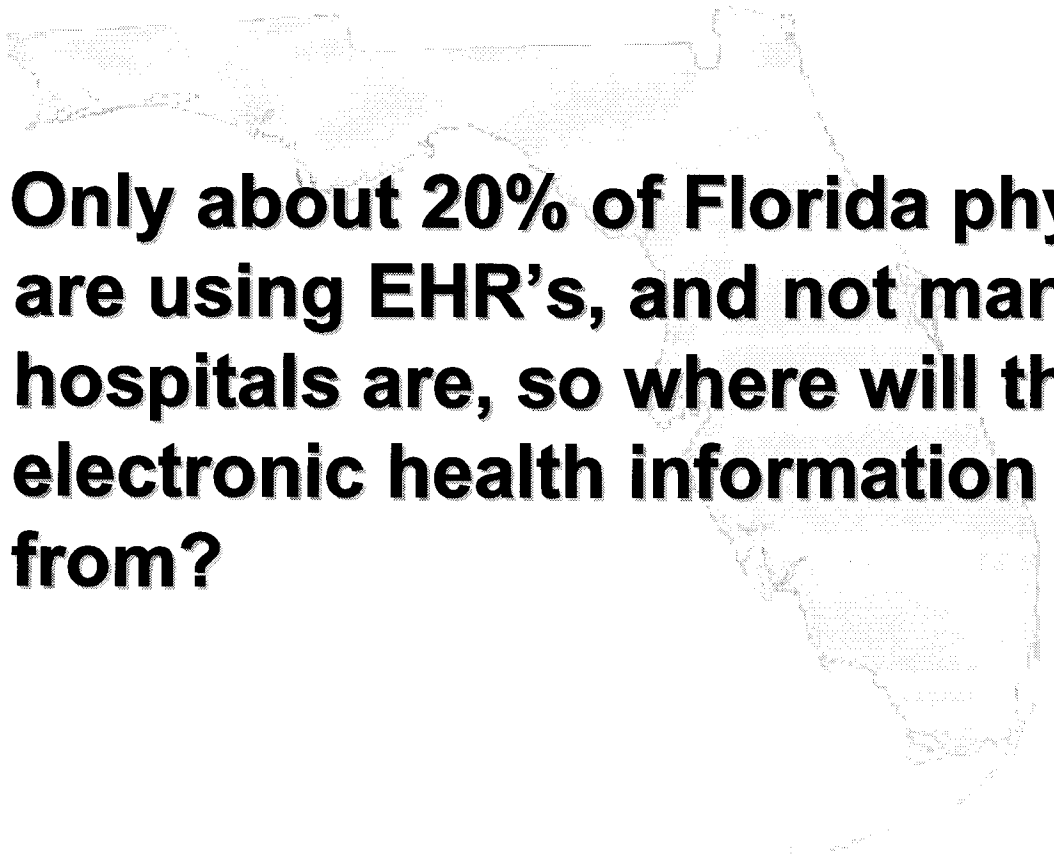
8. **The challenges we face are not so much technical as "human" challenges.**

9. **FHIN must be financed through a diversity of funding sources – need to receive federal, state and local governmental support, but also private funds.**

Recommended Strategic Framework



- Promote adoption of effective EHR systems among Florida providers
- Develop the Florida Health Information Network
- Organization of the Florida Health Information Network – Governmental at inception, public/private partnership at maturity



Only about 20% of Florida physicians are using EHR's, and not many more hospitals are, so where will the electronic health information come from?

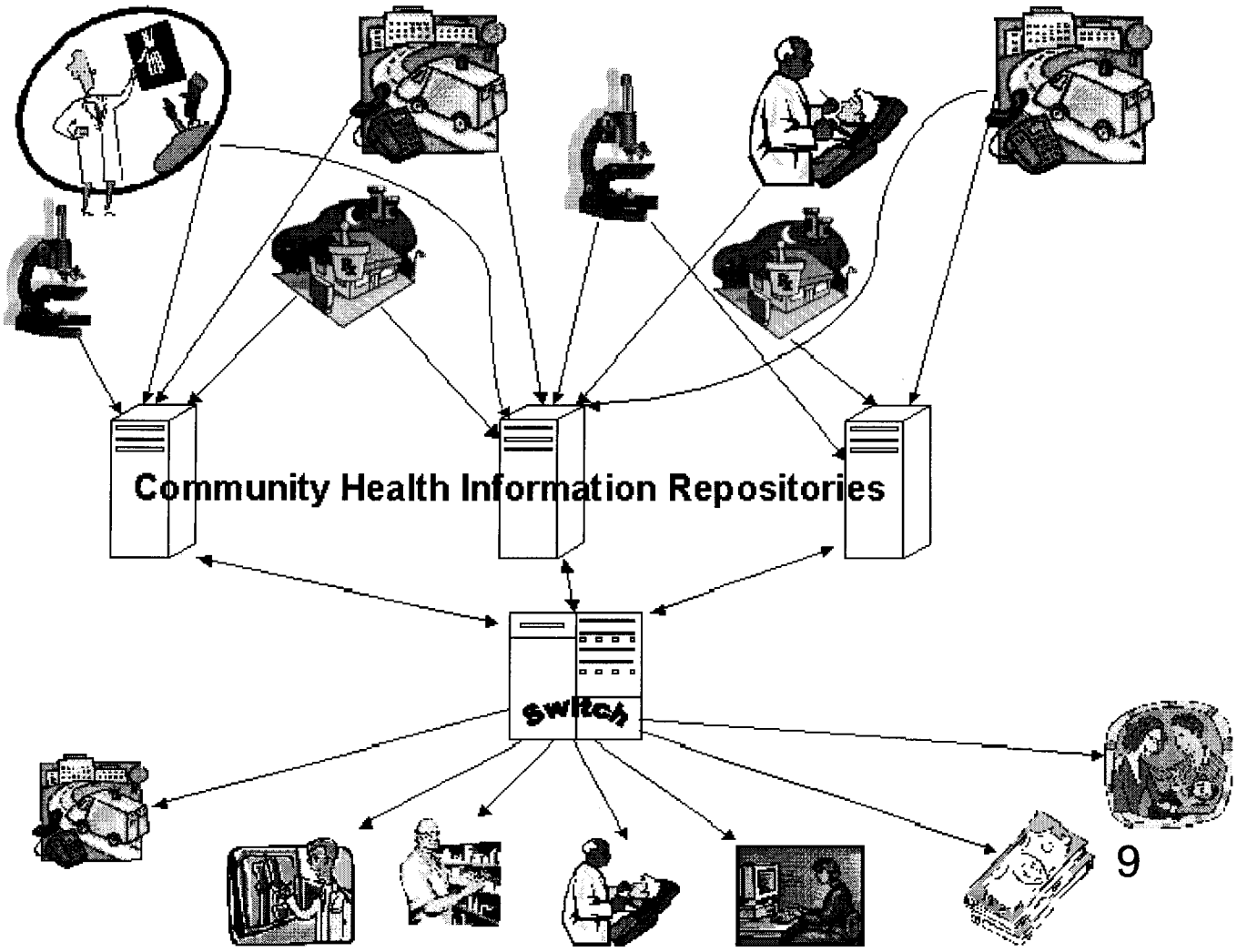
In order to have an interoperable network, health information must be electronically:

Captured >>>

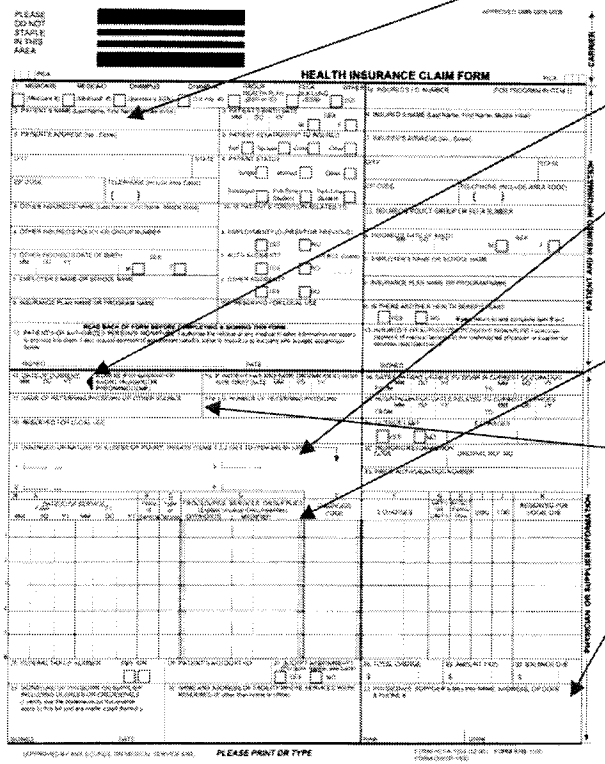
Stored >>>

and . . .

Retrieved >>>



In an environment of low EHR usage, what meaningful electronic health information is available to be shared?



Patient Demographic info

Date of treatment

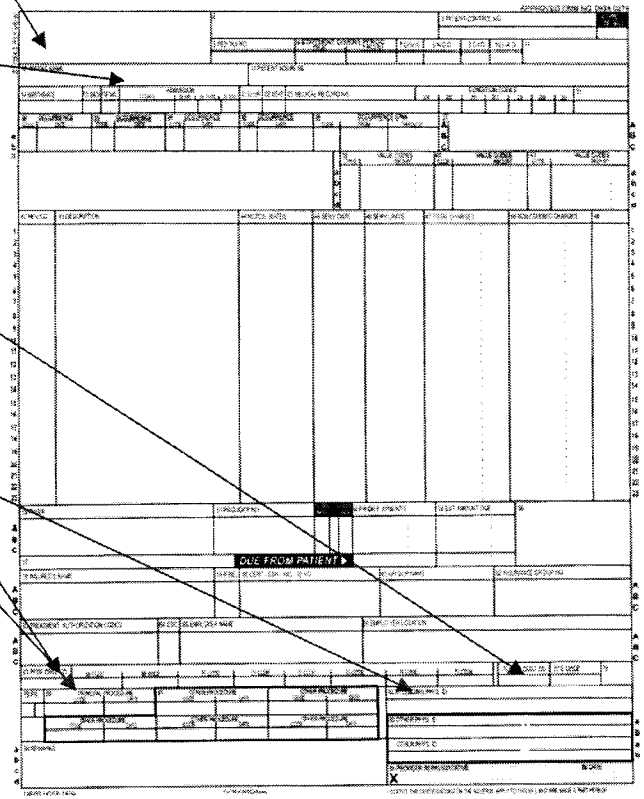
Diagnosis

Procedures

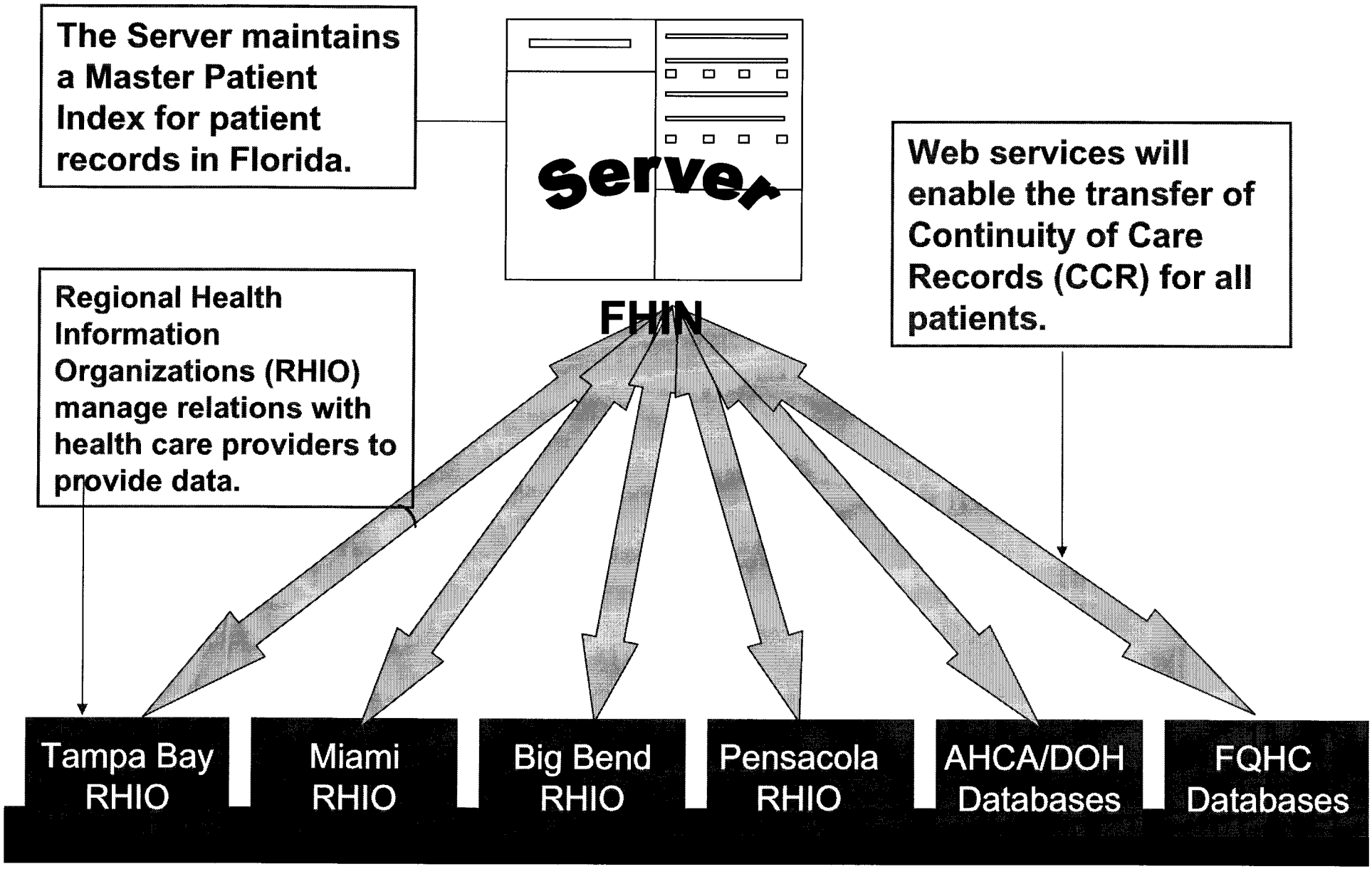
Identities of treating and referring providers and contact information

(Medications)

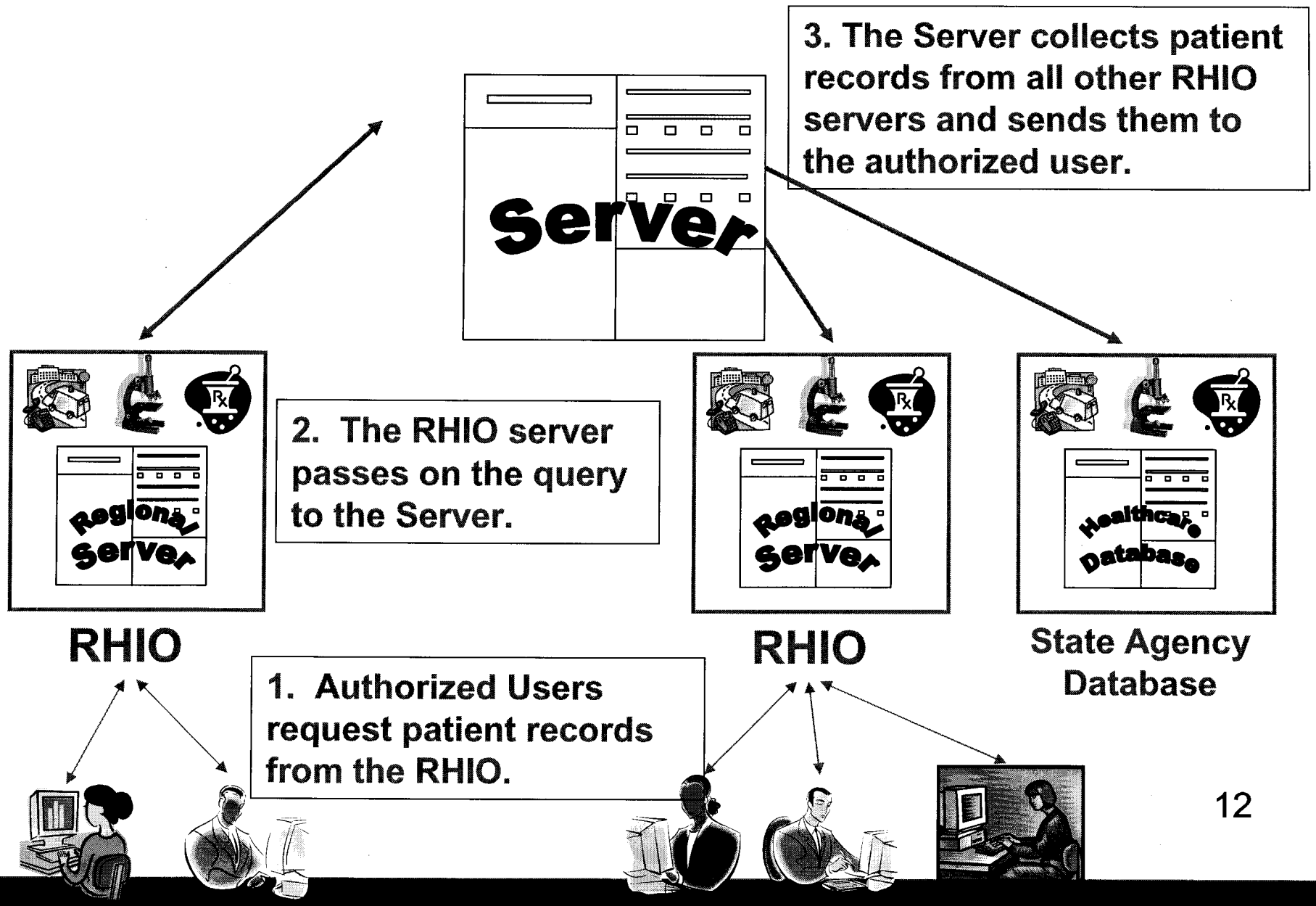
(Lab values)



FHIN Architecture



Potential Workflow



Florida Health Information Network – First Steps

- Incorporate FHIN, Inc.
- Conduct initial investment round
- Obtain tax status as a charity under Section 501(c)(3)
- Recruit organizational staff
- Promote participation in, and support for FHIN among Florida healthcare stakeholders
- Establish governance model – Board, advisors, etc.
- Develop and implement statewide infrastructure
- Nurture pilot projects – funding, management, etc.
- Conduct critical baseline studies and projects – stakeholder attitudes and opinions surveys, state coordinated health informatics initiative framework, etc.
- Execute information and education program

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

FOR IMMEDIATE RELEASE
November 8, 2005

CONTACT: Jonathan Burns
(850) 922-5871

AGENCY FOR HEALTH CARE ADMINISTRATION ANNOUNCES THE LAUNCH OF FLORIDA COMPARE CARE

~This consumer-friendly website will provide useful information to consumers about the health care facilities in their communities~

TALLAHASSEE - The Agency for Health Care Administration (AHCA) announced today the launch of the consumer health website www.floridacomparecare.gov. This interactive website is designed to be the first step in creating a more transparent health care system.

As part of an initiative mandated by House Bill 1629, AHCA has been working with the Comprehensive Health Information System (CHIS) Advisory Council to release a consumer-friendly website that will report performance measures on Florida's hospitals and ambulatory, or outpatient, surgery centers. The website will display the number of patients, charges, length of stay, readmission rates, mortality rates, and complication rates for various medical conditions and procedures in Florida's short term acute care hospitals.

"The Florida Compare Care website underscores AHCA's commitment to the transparency of health care information," said Secretary Alan Levine. "Florida's hospitals and health care facilities are among the best in the world. The more transparent our system is, the more likely we will see even better performance."

As a part of www.FloridaHealthStat.com, this website will also provide consumers the opportunity to compare information for specific facilities or to find information on a particular medical condition or procedure. Background information will be provided to the consumer to explain the data, provide descriptions of the medical conditions and procedures, and why the data may differ from facility to facility.

"By making this information public, hospitals will be able to highlight their strengths and create benchmarks for improvement," said Senator Durell Peaden.

"The Florida Legislature is committed to arming Florida's consumers with helpful information," said Representative Farkas. "Knowledge is power, and for consumers of health care, transparent health outcome data can be lifesaving."

(more)

The CHIS Advisory Council serves in an advisory role to AHCA, addressing various issues concerning the reporting of health care data and the presentation of consumer information. The CHIS Advisory Council is comprised of thirteen health care professionals who represent state and local agencies, the state universities, business and health coalitions, local health councils, professionals' health-care-related associations, consumers and purchasers.

Working to improve access to affordable, quality health care to all Floridians, the state Agency for Health Care Administration administers Florida's $15 billion Medicaid program, licenses and regulates more than 32,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics.

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FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

FOR IMMEDIATE RELEASE
January 4, 2006

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AGENCY FOR HEALTH CARE ADMINISTRATION ANNOUNCES THE ADDITION OF SURGICAL INFECTION PREVENTION (SIP) MEASURE DATA TO FLORIDA COMPARE CARE WEBSITE

~This consumer-friendly website will provide useful information to consumers about the health care facilities in their communities~

TALLAHASSEE - The Agency for Health Care Administration (AHCA) today announced the addition of Surgical Infection Prevention (SIP) data to the Agency's Florida Compare Care website. SIP is a measure of how well hospitals and physicians work to prevent infections arising from surgical procedures. Florida Compare Care is a consumer-friendly website launched in November 2005 that reports performance measures on Florida's hospitals and ambulatory, or outpatient, surgery centers.

"AHCA is committed to empowering consumers by bringing transparency to health information in the state of Florida," said Secretary Alan Levine. "With addition of Surgical Infection Prevention data, consumers will have even better access to the performance of the health care providers they rely on."

While hospitals use multiple practices to prevent and reduce infections, SIP measures relate to the use of antibiotics to reduce surgical infections and have been adopted at the national level by Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention and the Hospital Quality Alliance. While SIP data will initially be available on 56 facilities that report the information voluntarily, the information will be available on all 207 Florida facilities by late spring 2006, after reporting of the measure becomes mandatory under Agency rule.

Scientific evidence indicates that these measures represent the best practices for the prevention of infections for the following surgeries: colon surgery, hip and knee arthroplasty, abdominal and vaginal hysterectomy, cardiac surgery, coronary artery bypass grafts (CABG), and vascular surgery. The measures are:

- Surgery patients who received preventative antibiotic(s) one hour before incision
- Surgery patients whose preventative antibiotic(s) are stopped within 24 hours after surgery.

(more)

As part of an initiative mandated by House Bill 1629, AHCA worked in conjunction with the Comprehensive Health Information System (CHIS) Advisory Council to release Florida Compare Care. The website displays the number of patients, charges, length of stay, readmission rates, mortality rates, and complication rates for various medical conditions and procedures in Florida's short term acute care hospitals. The website can be accessed at www.floridacomparecare.org.

The CHIS Advisory Council serves in an advisory role to AHCA, addressing various issues concerning the reporting of health care data and the presentation of consumer information. The CHIS Advisory Council is comprised of thirteen health care professionals who represent state and local agencies, the state universities, business and health coalitions, local health councils, professionals' health-care-related associations, consumers and purchasers.

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Health Care Survey

HEALTH CARE SURVEY

Member Name: _____
E-mail address: _____

Legislative Assistant's Name: _____
E-mail address: _____

District Phone Number: _____
Tallahassee Phone Number: _____

Below is a partial list of types of health care entities and organizations. Which are you most interested in learning more about?

____ Advocacy groups
____Assisted Living organizations
____Child welfare
____Children's health
____Chronic diseases
____Dentistry
____Developmentally disabled
____Health insurance companies
____Hospital organizations
____Managed care organizations
____Mental health
____Minority health
____Nursing
____Nursing home organizations
____Other health care professional groups
____Other provider groups
____Pharmaceutical companies
____Pharmacy industry
____Physically disabled
____Physician groups
____Public health
____Substance abuse
____Women's health

Other: _____

What types of health care issues are you most interested in?

1. _____
2. _____
3. _____

Do you have suggestions for improving your experience as a member of the Health and Families Council and/or its Committees? _____
_____
_____
_____
_____